STATEMENT OF THE CASE

Petitioner Jean Levine suffered injuries in a slip-and-fall accident on an improperly maintained sidewalk on January 7, 1995. As a result of her injuries, she received medical treatment, some of which was paid for by respondent United Healthcare Corp. ("United") under the terms of a health insurance policy issued in connection with employment. Levine brought an action for personal injuries against several entities responsible for the sidewalk's maintenance, but in that action was barred by New Jersey's collateral source statute, N.J.S.A. 2A:15-97, from recovering any loss insured by a third party – such as the healthcare expenses covered by her insurance plan. Notwithstanding this statutory bar to Levine's own recovery of healthcare expenses, United claimed that its insurance policy gave it a right to demand reimbursement of its medical expenditures out of any recovery she obtained in her personal injury action. When her lawsuit was settled in early 2001, Levine reimbursed $11,000 to United from her settlement proceeds.

Petitioner Noreen Bogurski was injured in a motor vehicle accident on July 19, 1997. Part of her resulting medical treatment was paid for by respondent Horizon Blue Cross Blue Shield of New Jersey ("Horizon") under terms of a health insurance policy provided through her employment. Bogurski brought suit against the at-fault drivers for personal injury and consequential losses, but in that action was barred by New Jersey's collateral source statute, N.J.S.A. 2A:15-97, from recovering any loss insured by a third party, including the healthcare expenses covered by her insurance plan. Notwithstanding this statutory bar to Bogurski's own recovery of healthcare expenses, Horizon claimed its insurance policy gave it a

right to demand reimbursement of its medical expenditures out of any recovery she obtained in her personal injury action. When her lawsuit was settled in late May of 2001, Bogurski was to reimburse Horizon $11,000 from her settlement proceeds; those funds are still being held in escrow pending final resolution of this action.

On June 26, 2001, the New Jersey Supreme Court ruled that under New Jersey law, healthcare insurers never had a right to demand subrogation or reimbursement from their insureds, and that any such contractual language in a health insurance policy was void where the state's collateral source statute applied to an insured's civil claims. The court held that the collateral source statute specifically determined insurers' liabilities, and found that the state's Insurance Commissioner had exceeded his authority in allowing insurers to include any provision that altered that legislative allocation. *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001). As a result, the Insurance Commissioner directed all health insurers "immediately to cease all subrogation and recovery efforts against persons covered by group or individual contracts or policies issued in New Jersey," and further announced that the regulations governing permissible insurance clauses would be amended to conform to the *Perreira* ruling. N.J. Division of Insurance Bulletin No. 01-11, dated July 5, 2001.

Plaintiffs brought these actions in the Superior Court of New Jersey on behalf of themselves and all others similarly situated, asserting that their health insurance companies had demanded reimbursement for healthcare expenditures in violation of New Jersey law. In their Complaints, plaintiffs advanced liability theories of unjust enrichment, money had and received, and amendment by

operation of law, and sought, *inter alia*, declaratory judgment, injunctive relief, and compensatory and punitive damages. Notwithstanding the exclusively state-law nature of the underlying lawsuits, defendants removed the cases to federal court, claiming entitlement to federal jurisdiction by invoking the preemptive effect of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), and specifically ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

Plaintiffs moved for remand of these cases to the state court on the grounds that federal jurisdiction was lacking because they pleaded no cause of action arising under federal law, nor did they seek to recover any "benefits due" or otherwise enforce any plan rights within the meaning of ERISA. Ruling on the issue in its Opinion and Order of May 28, 2002, the District Court frankly acknowledged that this jurisdictional question "presents a conceptually unclear area of law," but nevertheless concluded that plaintiffs' claims were "actually claims for benefits" under their ERISA-governed health plans and so were properly removed to federal court. *Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796, 798 (D.N.J. 2002), App. 128, 130-131, 144-145.

Plaintiffs filed a motion to amend the District Court's Order denying remand to include language that would permit interlocutory appeal under 28 U.S.C. § 1292(b). The District Court denied that application without prejudice in an Opinion and Order dated July 24, 2002, App. 118, 120, 126-127. Subsequently, the District Court considered defendants' respective motions to dismiss plaintiffs' actions. The dismissal motions were denied in an Opinion and Order dated March 4, 2003, in which the court expressly found, *inter alia*, that the New Jersey collateral

source statute was a law that regulates insurance and therefore saved from preemption by ERISA. *Carducci v. Aetna U.S. Healthcare*, 247 F.Supp.2d 596 (D.N.J. 2003), App. 64, 91-96.

Thereafter, defendants sought certification for interlocutory appeal of the District Court's rulings on dismissal, and plaintiffs renewed their motion for certification of the jurisdictional issue decided previously. In an Opinion and Order dated October 6, 2003, the District Court noted that in the intervening period since plaintiffs' last application for certification for interlocutory appeal, a number of cases had been reported that indicated there are "substantial grounds for debate about this Court's 'benefits due' decision." *Levine v. United Healthcare Corp.*, 285 F.Supp.2d 552 (D.N.J. 2003), App. 34, 58-60.

The Third Circuit granted both defendants' petition and plaintiffs' cross-petition for leave to appeal in an Order dated January 14, 2004. On March 16, 2005, two of the three judges on a panel of the court ruled that the actions should be dismissed because the New Jersey collateral source statute was not a law that regulates insurance within the intendment of ERISA's savings clause, and was therefore preempted and could not be applied to modify the insurance policies at issue. *Levine v. United Healthcare Corp.*, 402 F.3d 156 (3d Cir. 2005), App. 1, 16-19. The third judge dissented, writing that he would find the New Jersey statute to be specifically directed toward the insurance industry and therefore saved from preemption. App. 19-30. Plaintiffs petitioned for rehearing or rehearing *en banc*, which was denied in an Order dated June 24, 2005. App. 146-148.

ARGUMENT

I. THE THIRD CIRCUIT COURT OF APPEALS HAS DECIDED AN IMPORTANT FEDERAL QUESTION IN A WAY THAT CONFLICTS WITH A DECISION BY THE NEW JERSEY SUPREME COURT.

The ruling by the Third Circuit panel majority that the New Jersey collateral source statute is not a law that "regulates insurance" within the meaning of ERISA is directly contrary to the state Supreme Court's description of the statute as specifically targeted to affect the insurance industry. As Judge Garth spelled out in his dissent from the panel opinion, "This case involves a *statutory enactment*, which, according to the New Jersey Supreme Court, was clearly rooted in *legislative concerns about spiraling insurance costs*. The New Jersey Supreme Court was emphatic in emphasizing insurance in its opinion [in *Perreira*]." App. 26 (block quotation omitted; emphasis in the original).

Here, the District Court had properly determined that the New Jersey collateral source statute regulates insurance and is therefore saved from ERISA's preemptive effect. The public policy and legislative history of the statute clearly demonstrate that it falls squarely under the protections of ERISA's savings clause. The savings clause "saves" from ERISA preemption any state law regulating insurance:

> Except as provided in subparagraph (B) [the 'deemer' clause], nothing in this subchapter shall be construed to exempt or relieve any person from any laws of any state which regulates insurance, banking or securities.

ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

In interpreting and applying the collateral source statute, New Jersey's courts have expressly and repeatedly noted that it was specifically aimed at the insurance industry. The measure was intended to contain spiraling liability insurance costs and to allocate the burden of losses within the insurance industry, shifting ultimate responsibility for healthcare expenditures from liability and casualty insurers to health and disability third-party payers. *See Perreira,* 169 N.J. at 410-411, 778 A.2d at 436 and cases cited therein (also noting that the legislative history of the statute revealed an express public policy choice to favor liability insurers over health insurers). In *Perreira*, the New Jersey Supreme Court explained the history of the statute and its intended effect on insurance. It quoted the Passed Bill memo prepared by the Governor's counsel, which stated:

> This bill attempts to reduce the cost of liability insurance by reducing the likelihood of a "double recovery" in a liability award for items which were already compensated by insurance or by other "collateral" sources, other than a tortfeasor.

Id. at 410, 778 A.2d at 436. The court concluded that the statute had more than one purpose, including: 1) disallowing double recovery to plaintiffs; and 2) containing spiraling insurance costs. *Id.* The court observed that the legislature made a "separate legislative decision" as to which "segment of the insurance industry" would be the beneficiary of the disallowance of double recoveries, and noted that the legislature decided to favor the liability insurance carriers by preventing health insurers from collecting on subrogation and reimbursement claims. *Id.* at 410-411, 778 A.2d at 436. As pointed out in numerous prior opinions

of New Jersey courts, the legislative history of the collateral source statute plainly demonstrates that it was specifically directed toward insurance. *See Kiss v. Jacob*, 138 N.J. 278, 282, 650 A.2d 336 (1994) (statute's legislative history "strongly suggests that the Legislature's essential concern was with insurance-type benefits" and intent of the legislature was to control spiraling automobile-insurance costs); *Fayer v. Keene Corp.*, 311 N.J. Super. 200, 208, 709 A.2d 808 (1988) (purpose of the statute is to shift the burden from liability and casualty industry to health and disability third-party payors); *Parker v. Esposito*, 291 N.J. Super. 560, 565, 677 A.2d 1159 (1996) (purpose of collateral source statute is to prevent double recovery, thereby giving relief from increasing costs of liability insurance); *Lusby v. Hitchner*, 273 N.J. Super. 578, 591, 642 A.2d 1055 (App. Div. 1994) (legislative determination was not only to prevent plaintiffs from obtaining a double recovery but also to shift burden from liability and casualty insurance to health and disability third-party payors). In furtherance of this plainly articulated policy, the *Perreira* court found that the collateral source statute embodied an antisubrogation rule geared toward regulating the insurance industry, invalidating insurance clauses that contravened the statute's legislative purpose. The statute thus controls the terms of insurance policies, broadly prohibiting enforcement of subrogation and reimbursement clauses in health contracts and requiring that health insurers cover injuries for which there may be tort liability.

As further proof of the statute's direct effect on the insurance industry, in immediate response to the *Perreira* decision, the New Jersey Insurance Commissioner issued a directive enjoining subrogation recovery activity by

health insurers. Insurance Commissioner Bulletin No. 01-11, issued July 5, 2001. The state Division of Banking and Insurance has now fully reversed its pre-*Perreira* position and promulgated new regulations as a result of the case, expressly prohibiting the subrogation and reimbursement clauses the state Supreme Court found to be in conflict with the collateral source statute. *See* N.J.A.C. 11:4-42.10 (effective August 5, 2002).

In dismissing the New Jersey courts' interpretation of its own state law, the panel majority's decision in this case represents an unwarranted federal intrusion into a well-established area of state police power and regulatory authority. As a consequence, it is now unclear whether health insurers may once again assert the very subrogation and reimbursement claims that the state Supreme Court has found to be prohibited. By ruling that the collateral source statute is not a "law regulating insurance," the panel's decision in this case may have exempted all but a handful of health insurance policies from conformance with the state law articulated in *Perreira*; health policies that are provided in connection with employment, because they are also governed by ERISA, may now be freed from the state's antisubrogation rule by virtue of federal preemption. New Jersey has no express antisubrogation statute governing insurers; the state's rule derives only from the legislative policies animating the collateral source statute. With the panel's decision that the collateral source statute is preempted by ERISA, health insurers may now challenge the state's authority to disallow or otherwise regulate these clauses. Such a confrontation could be avoided simply by recognizing that the New Jersey collateral source statute and its antisubrogation rule are in fact laws regulating insurance.

II. THE THIRD CIRCUIT COURT OF APPEALS HAS ENTERED A DECISION IN CONFLICT WITH DECISIONS OF OTHER UNITED STATES COURTS OF APPEALS ON THE SAME IMPORTANT MATTER.

The panel's decision in this case conflicts with decisions of courts of appeals in at least three other circuits, as well as prior Third Circuit case law. In *Medical Mutual of Ohio v. DeSoto*, 245 F.3d 561 (6th Cir. 2001), the Sixth Circuit held that a California antisubrogation statute prohibiting a health insurer from recouping payments made on a participant's behalf – incorporating features similar to New Jersey's law – regulated insurance and thus was not preempted by ERISA:

> By preventing any such recovery or subrogation the terms of section 3333.1 govern the relationship between the insurer and the insured. As such, it is "specifically directed toward [the insurance] industry." . . . Supreme Court precedent supports our view. In *FMC*, the Supreme Court held that a common sense reading of the Pennsylvania antisubrogation statute, with language similar to [the California statute] indicated that the statute regulated insurance.

245 F.3d at 573 (footnote and citations omitted).[2]

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[2] In attempting to distinguish *DeSoto* from this case, the panel overlooked the actual language of Section 3333.1, which provides that it regulates insurance as well as other contributions or sources of collateral benefits, including "any contract or agreement of any group . . . to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services . . . " 245 F.3d at 569. Thus, contrary to the panel opinion, the California statute also included situations where the statute may affect entities other than insurers.

The Fourth Circuit has ruled similarly, notably in *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), finding the antisubrogation provision of the Maryland HMO Act is saved from preemption as a state regulation of insurance; *see also Hampton Indus. v. Sparrow*, 981 F.2d 726, 729-30 (4th Cir. 1991) (North Carolina statute limiting subrogation was within ERISA savings clause). In *Singh*, the Maryland HMO Act regulated persons or organizations that provided "prepaid healthcare." The Maryland Court of Appeals construed the Act to prohibit an HMO from pursuing its members for reimbursement. 335 F.3d at 281. The Fourth Circuit rejected the insurer's "overly formalistic" argument, similar to the panel's decision here, that the HMO Act was outside the reach of the ERISA savings clause because it was located in the state statutes separate from the general insurance statutes and because HMOs were not classified as "insurers." *Id.* at 284-85. Instead, the Fourth Circuit found that the HMO law could provide its own form of insurance law and recognized that the savings clause analysis involved not a formalistic classification of an entity, but "whether the state law is aimed at the provision of insurance." *Id.* Since the Maryland law, like the New Jersey law at issue here, addresses "who pays in a given set of circumstances," it was "difficult to imagine an antisubrogation law of this type as anything other than an insurance regulation." *Id.* at 286.

The Ninth Circuit has also found that state antisubrogation rules are insurance regulations saved from ERISA preemption. *United Food & Commercial Workers & Employers Health & Welfare Trust v. Pacyga*, 801 F.2d

1157, 1161 (9th Cir. 1986) (Arizona common law disallowing subrogation is law regulating insurance and within the protection of ERISA's savings clause).

Likewise, the Third Circuit itself has previously found that state law limits on subrogation recoveries appear to be directly aimed at the insurance industry and therefore fall within the savings clause. *Bill Gray Enterprises, Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206 (3d Cir. 2001) (Pennsylvania antisubrogation statute regulates insurance and is thus within savings clause); *see also FMC Corp. v. Holliday*, 885 F.2d 79, 85-86 (3d Cir. 1989), *rev'd on other grounds*, 498 U.S. 52 (1990) ("Both parties and the amicus agree that the type of antisubrogation provision found in the Pennsylvania Financial Responsibility Law 'regulates insurance' within the meaning of the savings clause.").

Furthermore, District Courts – including the District Court in this case – have regularly found both common law and statutory antisubrogation provisions to be within the scope of the ERISA savings clause. *See, e.g., Carducci v. Aetna U.S. Healthcare*, 247 F.Supp.2d 596 (D.N.J. 2003), App. 91-96; *Donlan v. Greater Cleveland Reg'l Transit Auth.*, 2000 WL 485268 (N.D. Ohio 2000) (Ohio antisubrogation statute is within ERISA's savings clause); *Blue Cross and Blue Shield of Alabama v. Fondren*, 966 F.Supp. 1093, 1097 (M.D. Ala. 1997) (Alabama law of subrogation is saved from preemption); *Health Cost Controls v. Ross*, 1997 WL 222877 at *6 (N.D. Ill. 1997) ("consensus in this jurisdiction is . . . that Illinois' anti-subrogation law is saved from preemption by the savings clause"); *Health Cost Controls v. Whalen*, 1996 WL 787163, *2 (E.D. Va. 1996) (insured group insurance plan is subject to direct state law regulation by Virginia antisubrogation

statute); *Blue Cross and Blue Shield of Alabama v. Lewis*, 754 F.Supp. 849 (N.D. Ala. 1991); *Board of Trustees of Montana Teamsters Employers v. Coyne*, 628 F.Supp. 561 (D.Mont. 1986) (Montana common law voiding subrogation clause in group health policy is saved from preemption).

It is clear that antisubrogation law by its very nature is insurance regulation, as it addresses which entities provide benefits to cover losses in a given set of circumstances. By ruling to the contrary in this case, the panel decision is anomalous and in conflict with other federal courts.

III. THE THIRD CIRCUIT COURT OF APPEALS HAS DECIDED AN IMPORTANT FEDERAL QUESTION IN A WAY THAT CONFLICTS WITH RELEVANT DECISIONS OF THIS COURT.

The panel decision in this case is contrary to decisions of the United States Supreme Court, including (without limitation) *Kentucky Assn. of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). The panel simply did not address Supreme Court cases that establish a presumption against preemption of areas of traditional state regulation, or that defer to a state court's interpretation of its own state law; nor did the panel give proper consideration to Supreme Court cases holding that state antisubrogation laws are saved from ERISA preemption.

For example, this Court has held that under ERISA § 514(b)(2)(A) there is a presumption *against* preemption. *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 741 (1985). The Supreme Court has

long observed that, in determining the preemptive effect of federal law, the "ultimate touchstone" is congressional intent. *See, e.g., Cippolone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). This inquiry is "guided by respect for the separate spheres of governmental authority preserved in our federalist system." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). Construction of a federal statute begins "with the assumption that the historic police powers of the States [are] not to be superceded . . . unless that [is] the clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). Thus, it must be presumed that Congress did not intend to preempt areas of traditional state regulation, such as the New Jersey law at issue here. *See Metropolitan Life*, 471 U.S. at 741, *citing Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977).

The test for deciding whether a state law regulates insurance asks (1) whether the law is "specifically directed toward" entities that engage in insurance; and (2) whether the law "substantially affects the risk pooling arrangement between the insurer and the insured." *Kentucky Assn. of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-342 (2003).[3] The test focuses on whether a state law is specifically directed at the provision of insurance, and not on how or where an entity is classified in a statutory scheme.

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[3] The panel here recognized that the first factor of the *Miller* test was consistent with prior law, but that the second factor differed somewhat from earlier Supreme Court jurisprudence, which had used a three-factor test derived from case law interpreting the McCarran-Ferguson Act, 14 U.S.C. § 1101 *et seq*. The panel majority did not, however, apply the second factor at all in its decision, while the dissent pointed out that "there is no serious dispute" that state law at issue in fact spread policyholder risk. *See* App. 22 (Garth, dissenting).

The panel majority here found that the New Jersey collateral source statute had its primary effect on insurers and was intended to affect the insurance industry, but nevertheless was not "specifically directed" toward the insurance industry because its language was not limited solely to insurers; thus, it might sometimes encompass "benefits" received from entities other than insurers, and might sometimes profit self-insured or uninsured tortfeasors. However, despite such over-inclusiveness, the law *always* precludes any health insurer's subrogation or reimbursement claim against its insured.

The majority decision here failed to accord due regard to the New Jersey Supreme Court's explicit determination that the state statute was expressly enacted to address legislative concerns about insurance costs and to allocate responsibility for coverage within the insurance industry. *See Perreira*, 169 N.J. at 410-11, 778 A.2d at 436. The Supreme Court has consistently held that determinations of a state court concerning state policy and analysis of state statutes are highly relevant. *See Bush v. Palm Beach County Canvassing Bd.*, 531 U.S. 70, 76 (2000) ("As a general rule, this Court defers to a state court's interpretation of a state statute"); *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 372 (1999) (finding that a California statute was "grounded in policy concerns specific to the insurance industry" after reviewing state court decisions regarding public policy behind the statute); *Mullaney v. Wilbur*, 421 U.S. 684, 691 (1975) ("This Court, however, repeatedly has held that state courts are the ultimate expositors of state law, . . . and that we are bound by their constructions except in extreme circumstances") (internal citations omitted); *Missouri v. Hunter*, 459 U.S. 359, 368 (1983) (where state supreme court had construed state statutes at issue, Court "was bound to accept the [state

supreme] court's construction of that State's statutes") (internal citation omitted).

The New Jersey Supreme Court's decision in *Perreira* interpreted the New Jersey statute, examined its legislative history and made clear that the statute focused on insurance issues. In this case, however, the panel's inquiry centered on the breadth of the statute's wording and relied on the location and heading of the statute in deciding its meaning.[4] But contrary to the panel majority's decision, the title of a statute and the heading of a section cannot limit the law's plain meaning, and are merely among the many tools available for resolving doubt about an ambiguous word or phrase. *Curri v. Reno*, 86 F.Supp.2d 413, 417-418 (D.N.J. 2000); *see also Brotherhood of R.R. Trainmen v. Baltimore & O.R. Co.*, 331 U.S. 519, 528-29 (1947) (headings and titles are not meant to take the place of the detailed provisions of the text).

In addition, the majority decision failed to give weight to Supreme Court cases examining provisions limiting subrogation recoveries, which have consistently found them to fall within ERISA's savings clause. For example, in *FMC Corporation v. Holliday*, 498 U.S. 52 (1990), the Supreme Court examined whether ERISA preempted a Pennsylvania antisubrogation statute which, like the New Jersey statute at issue in this case, precluded an insurer's reimbursement from a claimant's tort recovery. The Court

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[4] Specifically, the panel emphasized the placement of the statute in Title 2A of the New Jersey statutes, which generally concerns the administration of justice, as well as the applicability of the statute to plaintiffs in "any civil action" who receive benefits from "any source" other than a joint tortfeaser, to support its conclusion that the statute is not specifically directed at the insurance industry.

found "that there was no dispute" that the antisubrogation statute was within the scope of the savings clause:

> [The statute] directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. It does not merely have an impact on the insurance industry; it is aimed at it. This returns the matter of subrogation to state law.

498 U.S. at 60-61 (citations omitted).[5]

The Court has also found statutes to fall within the protection of the savings clause despite the fact that the law reaches beyond the insurance context alone. In *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724 (1985), for example, the Court considered whether a Massachusetts statute setting forth mandatory minimum mental healthcare benefits for insurance policies was saved from ERISA preemption. The insurers had argued that the Massachusetts statute was really a health law that operated on insurance contracts to accomplish its end and that it was not the traditional kind of insurance law intended to be subject to the savings clause. The Court rejected the attempt to draw a distinction between laws

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[5] The panel majority misses the point in attempting to distinguish *FMC* from the instant case by observing that the Pennsylvania statutes at issue there, 75 Pa. C.S. §§ 1719 and 1720, "explicitly regulated insurance," while here the statute might in some ways apply to both insurance and non-insurance entities. App. 18. However, Section 1720 of the Pennsylvania statute provides that in actions arising out of the use of a motor vehicle, there is no right of subrogation from a recovery with respect to the benefits payable under, *inter alia*, Section 1719. In turn, Section 1719 (entitled "coordination of benefits") refers to benefit payments by "any program, group contract other arrangements" for payment of benefits. 498 U.S. at 55. Thus, the statute on its face is not limited only to insurance.

that directly regulate only the insurer or the way insurance may be sold, and laws that regulate the substantive terms of insurance contracts. The Court concluded that almost every tribunal considering the issue has determined that mandated benefits laws, or laws regulating the substantive terms of insurance contracts, are laws that regulate insurance, and thus are within the scope of the savings clause. *Id.* at 741-42 & n.18. *See also UNUM Life v. Ward, supra* (California's notice-prejudice rule, under which an insurer must show that it was prejudiced by untimely proof of a claim before it can avoid liability, is saved from ERISA preemption); *Kentucky Assn. of Health Plans v. Miller, supra* (rejecting argument that effect of law on non-insurers put statute beyond reach of savings clause, and holding that ERISA's savings clause does not require that a state law regulate "insurance *companies*" or even "*the business of insurance*" to be saved from preemption; it only need be a "law," "which regulates *insurance*."); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366, 370 (2002) (fact that the statute at issue was drawn to encompass entities other than insurers did not serve to take the statute out of the reach of the savings clause). The majority decision here does not address why the principles of these cases should not apply to the New Jersey statute it considered, and it improperly limits the reach of the savings clause in a manner inconsistent with these precedents.

While the majority decision ostensibly relies on *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), that case actually compels the opposite ruling here. In *Pilot Life*, the Supreme Court considered a Mississippi common law action for bad faith that provides for punitive damages in any case where a party to a contract acted in bad faith in

breaching that contract. An ERISA plan participant who had been denied benefits sued in state court seeking, *inter alia,* punitive damages under the state's bad faith law. The Court found that the law was not specifically directed toward the business of insurance because it was generally applicable to all contract and tort actions, whether insurance-related or not. 481 U.S. at 50. As the Court explained, "in contrast to the mandated-benefits law in *Metropolitan Life,* the common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages." *Id.* at 51. Thus, the Court concluded that the state common law of bad faith was no more integral to the insurer-insured relationship than any state's general contract law is integral to contracts made in that state.

Significantly, in *Pilot Life* the Mississippi Supreme Court had *not* ruled that the common law of bad faith was directed to the insurance industry, but only that it was applied in the insurance context. By contrast, the New Jersey Supreme Court in *Perreira* defined the statute at issue here as one specifically directed toward the insurance industry. 169 N.J. at 410-11, 778 A.2d at 436. Moreover, the panel majority here ignores the significant difference between the "general principles of tort and contract law available in any Mississippi breach of contract case" at issue in *Pilot Life*, 481 U.S. at 51, and the specific legislative enactment targeting the insurance industry, as interpreted by the New Jersey Supreme Court in *Perreira*. *See* App. 25-26 (Garth dissenting).

IV. THE THIRD CIRCUIT COURT OF APPEALS HAS DECIDED IMPORTANT QUESTIONS OF FEDERAL LAW THAT HAVE NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT.

In addition to the issues of "conflict preemption" presented by ERISA § 514, the Third Circuit panel's decision also touches on the doctrine of "complete preemption" of state law actions under ERISA § 502. This Court has not yet ruled on whether state-law claims such as those brought against the defendant health insurance companies here should be re-characterized as claims for "benefits due" under the plans, giving rise to federal jurisdiction and resulting in complete preemption of the claims pursuant to the civil enforcement provisions of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). While frankly acknowledging that this matter "presents a conceptually unclear area of the law," the District Court in this case likened plaintiffs' claims to complaints regarding the administration of benefits, "because they relate to the amount of benefits to which they are due under the ERISA plan." *Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796, 800 (D.N.J. 2002), App. 131-136. Yet it is undisputed that the sums plaintiffs seek to recover in their actions are *not* benefits that were due under their ERISA-governed plans, nor did they originate from those plans: The monies were in fact plaintiffs' property, received from third-party tortfeasors in settlement of personal injury claims *other than plan-covered medical expenses*. Thus, plaintiffs' actions here are not claims for plan benefits, but for damages resulting from the defendant insurers' unlawful conduct with respect to the entirely unrelated proceeds of plaintiffs' tort actions.

Whether the doctrine of "complete preemption" gives rise to federal jurisdiction in these cases depends on determining whether Congress intended its statutory scheme to completely occupy the field with respect to the law at issue, thereby rendering an action exclusively federal in character. *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 747 (1985). Thus, a civil action must have some basis in this "select group of claims" in order to be considered "necessarily federal in character." *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 354 (3d Cir. 1995), citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987).

The statutory subsection at issue here provides:

> A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan.

ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Citing the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Third Circuit has held that "preemption occurs when a state statute purports to provide a remedy for the violation of a right expressly guaranteed by [a section of ERISA] and exclusively enforced by § 502(a) [of ERISA]." *PAS v. Travelers Ins. Co.*, 7 F.3d 349, 356 (3d Cir. 1993).

Here, a straightforward reading of the plain text of the statute demonstrates that these matters fall completely outside the ambit of ERISA's civil enforcement clauses: Plaintiffs make no claim that defendants have failed to provide benefits, have denied plaintiffs' rights under their plans, or are withholding future benefits.

Quite to the contrary, plaintiffs seek only to recover monies taken by defendants out of their third-party recoveries for other losses, in contravention of New Jersey law.

The Third Circuit has held that in determining whether a plaintiff is seeking to "recover benefits due" under the terms of a plan, the statute "is concerned exclusively with whether or not the benefits due under the plan were actually provided." *Dukes*, 57 F.3d at 357. Plaintiffs here do not dispute that they received the plan benefits to which they were entitled.

Similarly, plaintiffs here are not seeking to enforce their rights under the terms of their plans. The Third Circuit has opined that this phrase in the statute was meant to encompass plan-created rights of plan participants other than the right to the benefits themselves, such as rights to the plan's benefit-claim and benefit-eligibility procedures. *Id.*

Finally, plaintiffs are not seeking to clarify rights to future benefits under their plans. There is no allegation that the plan has withheld or will withhold any benefits due under the plan. Plan participants are unquestionably entitled to future medical benefits under the plans, whether or not they initiate a third-party claim for their illness or injuries and whether or not the plans may make any claim for reimbursement .

Furthermore, a generalized characterization of a claim as broadly having something to do with "plan administration" does not result in complete federal preemption under § 502; instead, as articulated by the Third Circuit the claim must specifically concern the *administration of plan benefits and claims procedures to which*

participants or beneficiaries are entitled. See, e.g., Dukes, 57 F.3d at 357-58. In *Pryzbowski v. U.S. Healthcare*, 245 F.3d 266 (3d Cir. 2001), the Third Circuit noted that claims falling within the preemptive scope of § 502 include a beneficiary's action to obtain "accrued benefits due, a declaratory judgment about entitlement of benefits, or an injunction to require an administrator to pay benefits." *Id.* at 272, *citing Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987). The *Pryzbowski* court noted that to determine whether a claim is preempted by reason of being based on the administration of benefits, the test is whether the action concerns "'eligibility decisions' which 'turn on the plan's coverage of a particular condition or medical procedure for its treatment.'" 245 F.3d at 273, quoting *Pegram v. Hedrich*, 530 U.S. 211 (2000). "[T]he ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted. . . ." *Id.* Again, nothing in plaintiffs' complaints here touches on any decisions about eligibility for coverage of any condition or medical procedure, and the claims raised therefore fall outside the scope of § 502(a).

Instead, these cases concern defendants' wrongful demands for money recovered by plaintiffs in their third-party tort cases, where New Jersey law guarantees that plaintiffs are to be free of such claims. As was the case in *PAS*, the defendant insurers in this case "do[] not, and could not reasonably, contend that any provision of ERISA expressly guarantees this same right," and accordingly, "a necessary requirement for preemption is missing here." *PAS v. Travelers Ins. Co.*, 7 F.3d at 356.

Significantly, the civil enforcement provisions of ERISA provide that an action may be brought by a plan

participant "to recover benefits due to *him* under the terms of his plan, to enforce *his* rights under the terms of the plan, or to clarify *his* rights to future benefits" (emphasis added). However, at the core of these actions is the *defendant insurers'* exercise of a purported contractual right under their plans to demand subrogation or reimbursement against their insureds. Plaintiffs here are not attempting to enforce any plan participants' rights under the plans; to the contrary, they are seeking redress for the defendant insurers' assertion of *their* contract rights created under unlawful portions of the plans.

The Supreme Court has held that ERISA plans have no such contractual rights guaranteed by the civil enforcement provisions of ERISA, ruling that ERISA § 502(a)(3) supplies no federal cause of action for a health plan's claimed contractual right of reimbursement. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). Thus, where no such right lies within the contemplation of ERISA's civil enforcement section, any claims relating to such a right cannot be deemed to be so exclusively federal in character as to require the preemption of state law. If Congress had intended ERISA to completely "occupy the field" with respect to a plan's contractual reimbursement and subrogation rights, it is nonsensical that actions regarding such rights should be confined to a state court's jurisdiction when brought by a health plan (as in *Great-West*) but be considered "completely preempted" by federal law when brought by a plan participant or asserted as a health plan's defense.

In fact, the concept of reimbursement or subrogation for medical expense claims has no support whatsoever in ERISA's statutory scheme. It exists because it has been unilaterally implanted by insurers in plan documents.

"ERISA says nothing about subrogation provisions. ERISA neither requires a welfare plan to contain a subrogation clause nor does it bar such clauses or otherwise regulate their content." *Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127 (3d Cir. 1996). Commentators have urged that the spirit and purpose of ERISA actually provide greater support for the outright prohibition of reimbursement than for its authorization, especially when viewed in light of considerations of equity and fairness (such as to a catastrophically injured plaintiff who must pay back all or most of a tort recovery to an insurer). *See, e.g.*, Baron, RM: *Public Policy Considerations Warranting Denial of Reimbursement to ERISA Plans: It's Time to Recognize the Elephant in the Courtroom*, 55 Mercer Law Review 595, 619, 633 (2004).

Further, this matter involves a significant question of the scope of federal preemptive power, in that the panel decision seriously undermines the New Jersey Supreme Court's ability to interpret its own state law, to regulate insurance contracts in accordance with that law, and to hold insurance companies accountable for breach of their state law duties. In rendering its decision in this case, the Third Circuit panel majority has effectively eviscerated the New Jersey Supreme Court's ruling in *Perreira*, usurping its authority to require the state's health insurers to conform their contracts to New Jersey law where coverage is provided as an incident to employment, and depriving New Jersey citizens of redress in state courts pursuant to state law.

CONCLUSION

For all the reasons set forth above, petitioners respectfully request that this petition for writ of *certiorari* should be granted.

Respectfully submitted,

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402 F.3d 156

United States Court of Appeals, Third Circuit.
Jean LEVINE, On behalf of herself and all others similarly situated
v.
UNITED HEALTHCARE CORPORATION
(DC NJ 01-cv-04964)
Noreen Bogurski
v.
Horizon Blue Cross Blue Shield of New Jersey
(DC NJ 01-cv-05339)
Benjamin Edmonson, On behalf of himself and all others similarly situated
v.
Horizon Healthcare Services, Inc., dba Horizon Blue Cross Blue Shield of New Jersey
(DC NJ 01-cv-05812)
United Healthcare Corporation Horizon Blue Cross Blue Shield of New Jersey, Appellants at No. 04-1224
Jean Levine, On behalf of herself and all others similarly situated
v.
United Healthcare Corporation (DC NJ 01-cv-04964)
Noreen Bogurski
v.
Horizon Blue Cross Blue Shield of New Jersey
(DC NJ 01-cv-05339)
Jean Levine, Noreen Bogurski,*Benjamin Edmonson, Appellants at No. 04-1225.
*(Dismissed pursuant to Court's order of 11/17/04).
Nos. 04-1224, 04-1225.

Argued Dec. 15, 2004.
March 16, 2005.

William F. Hanrahan, (Argued), Edward A. Scallet, Jason H. Ehrenberg, Groom Law Group Chartered, Washington, DC, for Appellants/Cross Appellees United Healthcare Corp.

Edward S. Wardell, (Argued), Kelley Wardell & Craig, Haddonfield, NJ, for Appellants/Cross Appellees Horizon Blue Cross, etc., et. al.

Donna Siegel Moffa, (Argued), Trujillo Rodriguez & Richards, Haddonfield, NJ, and Franklin P. Solomon, (Argued), Weitz & Luxenberg, Cherry Hill, NJ, for Appellees/Cross Appellants Noreen Bogurski.

Natalie Finkelman Bennett, Shepherd Finkelman Miller & Shah, Washington Professional Campus, Turnersville, NJ, for Appellees/Cross Appellants Jean Levine, etc.

Before NYGAARD and GARTH, Circuit Judges and POLLAK,* District Judge.

OPINION OF THE COURT

NYGAARD, Circuit Judge.

These interlocutory cross-appeals require us to address two different facets of the preemptive power of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001, *et seq.*, as it applies to the instant dispute over an insurer's claimed right of subrogation from an insured's third-party tort recovery. First, the insured ERISA plan participants, plaintiffs below, argue that the

* Honorable Louis H. Pollak, District Judge for the United States District Court for the Eastern District of Pennsylvania, sitting by designation.

District Court should have remanded their claims to state court for lack of federal subject matter jurisdiction. Second, the insurance providers, defendants below, maintain that the District Court should have dismissed the claims entirely, as they depend on state law that is expressly preempted by ERISA § 514, 29 U.S.C. § 1144. Finally, the insurance providers argue that the District Court should have dismissed the claims because the state law decision on which they rely, *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001), should not apply retroactively. All three questions raise issues of first impression in this circuit. We find the insurance providers' arguments more persuasive as to the first two issues, rendering consideration of *Perreira*'s retroactivity unnecessary. Jurisdiction is proper in the District Court, but the underlying claims are preempted by ERISA and must be dismissed.

I.

Jean Levine, Noreen Bogurski, and Benjamin Edmondson (the "Insureds") were injured by third-parties in separate, unrelated events and are the Appellees/Cross-Appellants in this appeal. Their health insurance providers, United Healthcare Corporation and Horizon Blue Cross and Blue Shield of New Jersey,[1] are the Appellants/Cross-Appellees (the "Providers"). At the time of the injuries, the Providers fulfilled their responsibilities to the Insureds under each health insurance policy by paying at least a portion of the Insureds' medical expenses.

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[1] Horizon Blue Cross and Blue Shield of New Jersey was the health insurance provider for both Bogurski and Edmonson. With respect to Edmonson, they were Horizon Healthcare Services, Inc., doing business as, Horizon Blue Cross and Blue Shield.

Each Insured then filed suit against the third party responsible for his or her injury. At that time, a New Jersey Department of Insurance Regulation permitted health insurance policies to include reimbursement and subrogation clauses. N.J. Admin. Code tit. 11, § 4-42.10 (1993) (repealed August 5, 2002).[3] Each of the relevant

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[3] The relevant regulation that provided for reimbursement and subrogation was repealed on August 5, 2002 and replaced with a "Prohibition on subrogation/third party liability provisions." The Regulation, prior to its repeal, was as follows:

> 11:4-42.10 **Provisions for subrogation and repayment of benefits**
>
> (a) Group policies and certificates providing health insurance may contain subrogation provisions that require the return to the insurer by a covered person of benefits paid for illness or injury up to the amount a covered person received from a third party through settlement, a satisfied judgement or other means, as compensation for the medical costs of such illness or injury, subject to the following:
>
> 1. Repayment of benefits shall be required only where the amount received for the third party through settlement, judgment or other means are specifically identified as amounts paid for health benefits which have been paid by the insurer under the group policy or certificate.
>
> 2. The repayment shall not exceed the amount of benefits paid by the insurer under the group policy or certificate for the particular illness or injury.
>
> 3. The group policy and certificate shall allow the covered person to deduct from the repayment to the insurer the reasonable pro-rata expenses incurred in effecting the third party payment.
>
> (b) Group policies and certificates providing health insurance may exclude or reduce the health benefits payable to or on behalf of a covered person to the extent that the covered person has already received payment from a third party for past or future health care costs for an illness or injury resulting from the negligence or intentional act of such third party.

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health insurance policies had such a clause. Consequently, when the Insureds sued their respective tortfeasors, the Providers acted within the bounds of both the health insurance policies and the Department of Insurance regulation by seeking reimbursement from the Insureds for benefits paid under the health insurance policies. The Insureds then paid a portion of their tort settlement to the Providers to settle the reimbursement claims.[3]

Subsequent to these settlements between the Insureds and the Providers, the New Jersey Supreme Court announced a decision in *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), holding that the Department of Insurance regulation conflicted with a New Jersey statute, and thus, was invalid.[4] As a result, subrogation and reimbursement provisions are no longer permitted in New Jersey health insurance policies. Notwithstanding their

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(c) Except as set forth in (b) above, no policy or certificate providing group health insurance shall limit or exclude health benefits as the result of the covered person's sustaining a loss attributable to the actions of a third party.

(d) Notwithstanding (a) or (b) above, disability income, long term care and accidental loss benefits and blanket insurance shall not be subject to subrogation or repayment of benefits received.

(e) Subrogation shall only be applicable when third party liability benefits may exist, subject to the restrictions set forth above.

[3] Levine paid $11,000 to settle her reimbursement claim, Bogurski placed $11,000 in escrow to settle her reimbursement claim, and Edmondson paid $1,383.43 to settle his claim.

[4] The *Perreira* decision held that the Department of Insurance Regulation, N.J. Admin. Code tit. 11 § 4-42.10 (the "regulation"), directly conflicted with the statute regulating deductions from plaintiff's awards in personal injury and wrongful death actions, N.J. Stat. Ann. § 2A:15-97 (2000) (the "statute").

earlier settlements, the Insureds sued the Providers in New Jersey state court to recover the amounts they paid to reimburse the Providers.

II. The District Court Proceedings

After being sued in New Jersey state court, the Providers removed the cases to federal court claiming complete ERISA preemption under section 502(a)(1)(B) of ERISA. The District Court denied the Insureds' motion to remand to state court. Concluding that the question of removal was a "conceptually unclear area of law," the District Court nonetheless determined that the Insureds sought to "recoup a benefit due under the plan," and thus, their claim was properly removed. The Court also denied the Insureds' request to certify the issue for appeal at that time.

The Providers also filed a motion to dismiss the claims. First, the Providers claimed that ERISA pre-empted New Jersey's statute; therefore, the statute did not apply to ERISA-governed plans. Second, they argued that the *Perreira* decision should not be applied retroactively.

The District Court concluded that the New Jersey statute was a statute "regulating insurance," and thus, was "saved" from ERISA preemption. First, as directed by the Supreme Court in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), the District Court made the "common sense determination" that the law was specifically directed toward the insurance industry because it was intended to directly affect and regulate that industry. Second, the Court tested the

results of its common sense determination by examining the three factors listed in the McCarran-Ferguson Act[5] and found that these factors supported the conclusion that the law regulated insurance. *See Moran*, 536 U.S. at 366, 122 S.Ct. 2151. Thus, the District Court found that the law was "saved" from ERISA preemption.

Having determined that New Jersey's statute applied to ERISA-governed plans, the District Court turned to the question of whether the *Perreira* decision should be applied retroactively. The District Court determined that, under New Jersey law, prospective application[6] is appropriate only if: "(1) the parties and the community justifiably relied on the prior rule, (2) the purpose of the new rule will not be advanced by retroactive application, and (3) retroactive application of the rule may have an adverse effect on the administration of justice." (App. at 40 (citing *Coons v. American Honda Motor Co.*, 96 N.J. 419, 476 A.2d 763, 767 (1984))). Here, the District Court concluded that the *Perreira* decision reflected New Jersey's existing law

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[5] The three McCarran-Ferguson factors are (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and, (3) whether the practice is limited to entities within the insurance industry. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002). These factors are no longer used in determining whether a law is saved from ERISA preemption. *Kentucky Assoc. of Health Plans Inc. v. Miller*, 538 U.S. 329, 341-42, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).

[6] Under New Jersey law, all opinions are applied retroactively unless prospective application is deemed appropriate. *See, e.g., Henderson v. Camden County Mun. Util. Auth.*, 176 N.J. 554, 826 A.2d 615, 620 (2003). Thus, absent a specific finding that the *Perreira* opinion should be limited to prospective application, the opinion would be applied retroactively.

and was not new and unanticipated. Consequently, it held that the *Perreira* decision applied retroactively.

Following the denial of the motion to dismiss, the District Court certified three issues for interlocutory appeal pursuant to 28 U.S.C. § 1292(b):

> (1) whether the antisubrogation rule contained in N.J.S.A. 2A:15-97, as interpreted by the New Jersey Supreme Court in *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), applies to defendant health insurers because it is not conflict preempted under ERISA section 514(a) because it is "saved" as a state law that regulates insurance;
>
> (2) whether *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), applies retroactively to plaintiffs' pre-*Perreira* health insurance plans; and,
>
> (3) whether plaintiffs' unjust enrichment claims for monies taken pursuant to subrogation and reimbursement provisions in their ERISA health plans are claims for "benefits due" within the meaning of ERISA section 502(a).[7]

We granted permission for the appeal (issues one and two) and cross-appeal (issue three) on January 16, 2004 and have jurisdiction pursuant to 28 U.S.C. § 1292(b).

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[7] Although the District Court cited to the New Jersey Reports, we cite to the Atlantic Reporter for the *Perreira* decision throughout this opinion. It should also be noted that the correct citation to the New Jersey Reports for the *Perreira* decision is 169 N.J. 399, 778 A.2d 429.

III. The Removal Claim: Preemption under Section 502(a)

We address the cross-appeal first because it requires us to examine our jurisdiction. We exercise plenary review over challenges to our subject matter jurisdiction. *Pryzbowski v. U.S. Healthcare Inc.*, 245 F.3d 266, 268 (3d Cir.2001). *See also Arana v. Ochsner*, 338 F.3d 433, 437 (5th Cir.2003) (*en banc*).

The Insureds brought their claims in New Jersey state court as state claims for unjust enrichment. Therefore, they claim, federal jurisdiction is inappropriate and the cases should be remanded to state court. In general, under the well-pleaded complaint rule, it is true that the federal courts have federal question jurisdiction only when a federal claim appears in the complaint, and not when a federal preemption defense may eventually be raised in litigation. *Pryzbowski*, 245 F.3d at 271. Certain federal laws, however, including ERISA, so sweepingly occupy a field of regulatory interest that any claim brought within that field, however stated in the complaint, is in essence a federal claim. In such cases, the doctrine of complete preemption provides federal jurisdiction and allows removal to federal court. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). State law claims seeking relief within the scope of section 502(a) of ERISA are within this select group of cases where Congress has completely preempted an area of law.[8]

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[8] When addressing preemption under section 502(a) we are dealing with "complete preemption," as opposed to "express preemption" which arises under section 514 of ERISA. *Pryzbowski*, 245 F.3d at 270. Compete [sic] preemption is a jurisdictional concept, and is distinguishable from questions which arise under section 514. *Id. See also, Barber*

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Metro. Life, 481 U.S. at 62-66, 107 S.Ct. 1542; *Pryzbowski,* 245 F.3d at 271-72. Thus, if the claim is one that falls within section 502(a) of ERISA, removal to federal court is proper. *Id.*

Section 502(a) allows a participant in an ERISA plan to bring a civil action to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). The District Court found that the Insureds' claims were actually claims for benefits due: "[e]ssentially plaintiffs seek to regain the whole benefit provided to them by defendants, including those amounts paid in subrogation pursuant to the terms of the plans. . . . [T]his Court must determine the content of the ERISA plan and whether the New Jersey Supreme Court case in *Perreira* applies to the subrogation provision in plaintiffs' ERISA plans." (App. at 193).

In *Pryzbowski,* we laid out a framework for determining whether a case is completely preempted under section 502(a) of ERISA. In order to ensure that Congress's intent of giving section 502(a) "extraordinary preemptive force" was fulfilled, we utilized the two categories of ERISA cases, originally set out by the Supreme Court in *Pegram v. Herdrich,* 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). *Pryzbowski,* 245 F.3d at 271. The first category involves cases where the claim challenges the administration of, or eligibility for, benefits. These cases fall within the scope of 502(a) and are preempted. *Id.* at 273. The

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v. UNUM Life Ins. Co., 383 F.3d 134, 141 (3d Cir.2004) (explaining express preemption under ERISA § 514(a)).

second group of cases challenges the quality of the medical treatment performed and is not preempted. *Id.* As noted by the District Court, this case does not fall squarely within either category. Thus, we must look beyond the framework set out in *Pryzbowski* to determine whether this case falls within section 502(a).

At the time of the District Court's ruling on the removal question, May 28, 2002, no Court of Appeals had considered whether the type of case before us was preempted under section 502(a) of ERISA. Since the District Court's initial ruling, however, the Fourth and Fifth Circuits have considered whether similar cases are subject to preemption under ERISA. *Arana,* 338 F.3d 433; *Singh v. Prudential Health Care Plan Inc.,* 335 F.3d 278 (4th Cir.2003). Both Courts of Appeal held that the federal courts are the proper forums for these disputes. In *Arana,* the Fifth Circuit held that federal jurisdiction was proper in a case strikingly similar to the one here. There, the plaintiff claimed that under Louisiana law his health insurance company had no right to reimbursement of health benefits after the plaintiff recovered in a tort action. The Court held that the plaintiff's claim was properly characterized as a claim for "benefits due" or to "enforce his rights under the plan," either of which would provide jurisdiction. *Arana,* 338 F.3d at 438. It described the situation as follows:

> As it stands, Arana's benefits are under something of a cloud, for OHP is asserting a right to be reimbursed for the benefits it has paid for his account. It could be said, then, that although the benefits have already been paid, Arana has not fully 'recovered' them because he has not obtained the benefits free and clear of OHP's claims. Alternatively, one could say that Arana

> seeks to enforce his rights under the terms of the plan, for he seeks to determine his entitlement to retain the benefits based on the terms of the plan. *Id.*

In *Singh*, the Fourth Circuit addressed whether claims of unjust enrichment and negligent misrepresentation relating to subrogation and reimbursement actions of the insurer were claims for "benefits due." Like the Fifth Circuit, the Fourth Circuit found that ERISA controlled and removal was appropriate because subject matter jurisdiction is not affected by "the fortuity of *when* a plan term was misapplied to diminish the benefit." *Singh*, 335 F.3d at 291 (emphasis in original).

Here, the Insureds claim that they were entitled to certain health benefits and that the Providers wrongly sought the return of those benefits. Even more than in *Arana*, the Insureds' claim here is for benefits due. The Insureds have already paid back a portion of their benefits. Thus, they claim essentially that they are entitled to have certain health insurance claims paid under their ERISA plans. It is impossible to determine the merits of the Insureds' claims without delving into the provisions of their ERISA-governed plans.

We agree with the reasoning of the Courts of Appeal for the Fourth and Fifth Circuits. Where, as here, plaintiffs claim that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for "benefits due" and federal jurisdiction under section 502(a) of ERISA is appropriate. Such a rule comports with our earlier jurisprudence because, although not directly analogous, such claims are more like challenges to the "administration of benefits" than challenges to the

"quality of benefits received." *See Pryzbowski*, 245 F.3d at 273.

Although the Insureds have attempted to characterize their claim as one looking only at state law, the essence of the claim concerns an ERISA plan. Therefore, we conclude that federal subject matter jurisdiction is appropriate.

IV. Express Preemption Under Section 514 of ERISA

Next, we turn to the District Court's denial of the Providers' motion to dismiss. Our review of the District Court's decision is plenary. *Pryzbowski*, 245 F.3d at 268. We accept all factual allegations in the complaint as true and draw reasonable inferences from those allegations. *Id.*

The first issue is whether ERISA preempts the New Jersey statute on which the Insureds' claims rely. If ERISA preempts the New Jersey statute, then the reimbursement provisions in the Insureds' health insurance policies stand, and the Insureds' claims must be dismissed. Because we find that this is indeed the case, this issue is dispositive.

New Jersey Statute, section 2A:15-97, essentially reverses the common law collateral source doctrine by requiring a plaintiff who receives benefits from *any* source other than a joint tortfeasor to deduct that amount from his or her recovery in *any* civil action.[9] Thus, payments

[9] The New Jersey Statute, N.J. Stat. Ann. § 2A: 15-97, reads:

In any civil action brought for personal injury or death, except actions brought pursuant to the provisions of P.L.1972, c.70 (C.39:6A-1 et seq.), if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds

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made by health care providers are deducted from a plaintiff's tort recovery under New Jersey law.[10]

Generally, a state law that "relates to" an ERISA-governed plan is preempted by ERISA. 29 U.S.C. § 1144(a). ERISA's expansive express preemption rule – as distinguished from the jurisdictional question of complete preemption discussed above – is set forth in Section 514(a) of the Act, and provides that ERISA's regulatory structure "shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan [subject to ERISA]." 29 U.S.C. § 1144(a) (emphasis added). The District Court has determined that the state law on which the Insureds rely "relates to" the Insureds' ERISA plans. That ruling is not before us for review. The Insureds' claims are thus preempted unless they fall within an exception to Section 514(a).

The relevant exception here is Section 514(b)(2)(A), or the "savings clause." The savings clause provides that, apart from particular scenarios not presented here,[11]

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from a life insurance policy, shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer directly by the plaintiff, or any member of the plaintiff's family on behalf of the plaintiff for the policy period during which the benefits are payable. Any party to the action shall be permitted to introduce evidence regarding any of the matters described in this act.

[10] The Insureds failed to plead in their complaint whether such amounts were withheld from their settlements. Because all of the Insureds settled their tort actions, we assume that such deductions would have been made if they had proceeded to trial.

[11] These excluded scenarios are set forth in the "deemer" clause, and exempt certain self-funded ERISA plans from the reach of state

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"nothing in [ERISA's preemption provisions] shall be construed to exempt or relieve any person from *any law of any state which regulates insurance,* banking or securities." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). Accordingly, the key question before us is whether the New Jersey law underlying the Insureds' claims is a law "which regulates insurance."

The Supreme Court recently clarified the appropriate test for determining whether a state law that relates to employee benefit plans falls within the savings clause. In a 2003 decision, issued after the District Court had made its preemption ruling in this case, the Court directed that for a "state law to be deemed a 'law . . . which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements." *Miller,* 538 U.S. at 341-42, 123 S.Ct. 1471. First, the state law must be "specifically directed toward entities engaged in insurance." *Id.* Second, the state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.*[12]

The Providers argue that the New Jersey statute applies to "*any* civil action" and funds from "*any* other source," and thus, it is not specifically directed toward insurance. In *Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), the Supreme Court addressed a similar case where a state law had its primary effect on insurers but was not limited to insurers. At issue in *Pilot* was Mississippi's law of bad faith. Even

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laws otherwise saved from preemption under the savings clause. The deemer clause is not at issue here. *See* 29 U.S.C. § 1144(b)(2)(B).

[12] This second factor, of course, marks a departure from the Court's earlier jurisprudence concerning the three McCarran-Ferguson factors, on which the District Court's decision was based.

though the Mississippi Supreme Court had identified its law of bad faith with the insurance industry, the Supreme Court found that the law was based in general tort and contract law, not insurance law. *Id.* at 49-50, 107 S.Ct. 1549. The law could apply in any breach of contract case, not merely a breach of an insurance contract. *Id.* As a result, the law did not fall within the savings clause. *Id.*

Here, the District Court found, and the Insureds argue, that the New Jersey statute is distinguishable from *Pilot* because it was specifically intended to benefit the liability insurance industry. Terming the statute an "anti-subrogation law," the Insureds contend that the statute is the result of a conscious tort reform effort by the legislature that shows a choice to shift the burden for tort recovery from liability insurers to health insurers. Although the legislative history and the *Perreira* decision do indicate an intent to lighten the burden on the liability insurance industry, we cannot say that the New Jersey statute is "specifically directed toward the insurance industry" for the purpose of the savings clause.

Before turning to the effect the statute has on New Jersey insurance law, an examination of the statute itself indicates that it is more than just an insurance regulation. New Jersey did not define section 2A:15-97 as an "antisubrogation law," nor did New Jersey place this statute among the statutes regulating insurance. Rather, the statute is entitled, "Personal injury or wrongful death actions; benefits from sources other than joint tortfeasor; disclosure; deduction from plaintiff's award," and is included in the portion of New Jersey's statutes dealing with civil actions. The plain language of the statute reveals that this statute is not limited to regulating either health insurance or liability insurance providers.

Additionally, examination of the driving intent behind the statute shows that this case parallels the analysis in *Pilot*. As in *Pilot*, a state supreme court described the law as one intended to affect the insurance industry. *Perreira*, 778 A.2d at 436. Despite this finding, the law here is a general law of civil procedure. The New Jersey statute governs all civil actions, not merely those involving insurance entities. Furthermore, even the *Perreira* Court recognized that the primary purpose of the law was to disallow double recovery by tort plaintiffs, not to regulate insurance contracts. *Id.*

The statute's general applicability is further exemplified by its plain language. The statute applies in "*any* civil action" to benefits received from "*any* other source." As in *Pilot*, the New Jersey law regulates non-insurance parties as well as insurance entities. For example, a plaintiff would be required to report any contribution, such as a private indemnity agreement, under the statute. Consequently, in some circumstances the statute will have no effect on health insurers at all. Furthermore, the Insureds heavily rely on the New Jersey legislature's intent to reduce the expense of liability insurance as evidence of the statute's specific intent to regulate the insurance industry. The statute, however, applies in all civil actions, not merely those in which liability insurers will pay the judgment. Thus, in some cases the statute will benefit private tortfeasors, and not insurance entities. Accordingly, as the Court found in *Pilot*, the New Jersey statute is merely one that will usually, although not exclusively, be applied to regulate insurance entities. *See Pilot*, 481 U.S. at 49-50, 107 S.Ct. 1549. This is not sufficient to avoid preemption under ERISA.

The Insureds argue that because the statute is "aimed at" insurance entities, the requirements under the savings clause are satisfied, even if in some cases the statute regulates non-insurance entities. They direct us to several cases where the fact that a statute is "aimed at" the insurance industry or intended to affect that industry supports the conclusion that it is specifically directed toward the industry. *See, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990) ("[I]t does not merely have an impact on the insurance industry; it is aimed at it."). Examination of these cases, however, reveals a key difference from the case here: they explicitly regulated insurance. *Miller,* 538 U.S. at 331-32, 123 S.Ct. 1471 ("a health insurer shall not discriminate against . . . "); *Moran,* 536 U.S. at 359, 122 S.Ct. 2151 (involving a section of Illinois's HMO Act where Congress specifically determined that HMOs were insurance entities); *Holliday,* 498 U.S. at 55, n. 2, 111 S.Ct. 403 (defining "coordination of benefits" as "a policy of insurance"); *Medical Mutual of Ohio v. deSoto,* 245 F.3d 561, 569 (6th Cir.2001) (examining California's antisubrogation statute that was limited to cases against a health care provider and contributions paid as the result of "health, sickness or income-disability insurance, accident insurance"). Although New Jersey's statute may have been "aimed at" shifting the burden of tort expenses from the liability insurance industry to the health insurance industry, the statute explicitly regulates both insurance and non-insurance entities. As in *Pilot,* we are faced with a state statute that, although commonly identified with the insurance industry, is not "specifically directed toward the insurance industry."

To avoid ERISA preemption a state law must be "specifically directed" toward the insurance industry. The

New Jersey statute is not. Because the New Jersey statute could be applied to any contributor in any civil action, it is merely a statute that has a significant impact on the insurance industry. As in *Pilot*, this is not sufficient. ERISA preempts the application of New Jersey's statute; therefore, the District Court erred in denying the Providers' motion to dismiss.

V.

Because we conclude that ERISA preempts application of New Jersey's statute, we need not address the retroactivity of the New Jersey Supreme Court's decision in *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001). We hold that the Insureds' claims are for benefits due, and thus were properly removed to federal court. We also hold, however, that ERISA preempts application of New Jersey's statute, and thus the District Court erred in denying the Providers' motion to dismiss. We reverse and remand with instructions for the District Court to dismiss the cause.

GARTH, Circuit Judge, dissenting.

This appeal, consisting of three consolidated actions, principally concerns two separate preemption issues: express preemption under § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a) ("ERISA"), and complete preemption under § 502(a) of ERISA, 29 U.S.C. § 1132. While I join Part III of the majority opinion because I agree that § 502(a) complete preemption exists, thereby establishing federal

subject-matter jurisdiction,[13] I must respectfully dissent from Parts IV and V of the majority opinion because, in my view, the New Jersey collateral source statute, N.J.S.A. 2A:15-97,[14] is saved from express preemption under § 514(a) of ERISA as a state regulation of insurance.

I.

Three provisions of ERISA § 514 speak directly to the question of express preemption,[15] the mechanics of which have been neatly summarized by the Supreme Court:

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[13] *See generally Arana v. Ochsner Health Plan*, 338 F.3d 433 (5th Cir.2003); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir.2003).

[14] The statute provides:

> In any civil action brought for personal injury or death, except actions brought pursuant to the provisions of P.L.1972, c. 70 (C. 39:6A-1 et seq.), if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds from a life insurance policy, shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer directly by the plaintiff or by any member of the plaintiff's family on behalf of the plaintiff for the policy period during which the benefits are payable. Any party to the action shall be permitted to introduce evidence regarding any of the matters described in this act.

N.J.S.A. 2A:15-97.

[15] Of the three provisions of § 514, which are set forth below, the first and third are not involved in this appeal. It is the second provision, § 514(b)(2)(A), which concerns the regulation of insurance, that this appeal focuses upon.

"Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this

(Continued on following page)

> If a state law "relate[s] to . . . employee benefit plan[s]," it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." § 514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 45, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). Although the express preemption analysis normally requires the application of the three relevant provisions of § 514, the sole issue in this appeal is whether the District Court erred as to the second step in the analysis in finding that N.J.S.A. 2A:15-97 is "saved" from preemption as a state statute that regulates insurance under § 514(b)(2)(A).[16] Accordingly, I confine my discussion to that narrow issue.

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chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." § 514(a), as set forth in 29 U.S.C. § 1144(a) (pre-emption clause). "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." § 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A) (saving clause).

"Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

[16] The two other clauses of § 514 – the "preemption clause" and the "deemer clause" are not the subject of the certified questions in this appeal. *See supra* note 3.

II.

In *Kentucky Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329, 341-42, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003), the Supreme Court rejected the previous use of the McCarran-Ferguson factors, and instead enunciated two requirements for a state law to be deemed a "law . . . which regulates insurance" under § 514(b)(2)(A). First, the state law must "be specifically directed toward entities engaged in insurance." *Id.* at 342, 123 S.Ct. 1471 (*citing Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549; *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 368, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999); *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 366, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002)). Second, the state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.*

Here, there is no serious dispute that state antisubrogation laws spread policyholder risk and therefore satisfy the second *Miller* requirement.[17] *See Singh,* 335 F.3d at 286 (noting that "it is difficult to imagine an antisubrogation law . . . as anything other than an insurance regulation, as it addresses who pays in a given set of circumstances and is therefore directed at spreading policyholder risk"); *Med. Mut. of Ohio v. deSoto,* 245 F.3d 561, 574 (6th Cir.2001) ("The logical effect of [antisubrogation laws] . . . is to decrease the premiums of health care providers' insurance and increase the premiums of health insurance – i.e., spread risks."). What concerns us in this appeal, then, is whether the New Jersey collateral source

[17] Indeed, United and Horizon do not attempt such an argument.

statute satisfies the first *Miller* requirement, *i.e.*, that it is specifically directed towards the insurance industry.

Focusing solely upon the statutory language, the majority concludes that the New Jersey collateral source statute is not specifically directed to the insurance industry because its definitions sweep too broadly and thereby encompass organizations or entities that do not provide insurance. To be sure, the collateral source statute does not specifically refer to health insurance or to subrogation and reimbursement clauses. It is contained in Title 2A of the New Jersey Statutes, which regulates the administration of civil and criminal justice. Moreover, the statute applies to plaintiffs "in any civil action" who receive benefits for their injuries from "any other source other than a joint tortfeasor." N.J.S.A. 2A:15-97. As the majority opinion notes, the term "benefits received" thus encompasses more than just insurance proceeds.

On the surface, therefore, this case would appear to present a paradigmatic example of a law of general application that has some bearing on insurers. Such laws do not qualify under the "saving" clause jurisprudence. *See Miller,* 538 U.S. at 334, 123 S.Ct. 1471. However, the inquiry does not end here, for the New Jersey Supreme Court has spoken in a rather definitive way as to the legislative purpose of the collateral source statute. *See Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001).

While recognizing that "[o]n its face, N.J.S.A. 2A:15-97 . . . is silent regarding any right to subrogation or reimbursement on the part of health insurers," *id.* at 409, 778 A.2d 429, the Supreme Court in *Perreira* determined that the statute had more than one purpose: "To be sure, its primary purpose was to disallow double recovery to

plaintiffs, *but a secondary goal was clearly the containment of spiraling insurance costs.*" *Id.* at 410, 778 A.2d 429 (emphasis added). In enacting N.J.S.A. 2A:15-97, the Court noted that the legislature made a "separate legislative decision" as to which "segment of the insurance industry" would be the beneficiary of the double recovery disallowance. *Id.* As the legislative history reveals, the Court noted, the choice was made to favor liability carriers.[18] *Id.* at 411, 778 A.2d 429 (citing cases agreeing that purpose of statute was to shift burden from casualty and liability insurance industry).

III.

I am persuaded that the foregoing statutory interpretation, coming, as it does, from the State's highest tribunal, compels the conclusion that the New Jersey collateral source statute is "specifically directed" towards the insurance industry. In my view, the majority opinion accords too little weight to such statements from the New Jersey Supreme Court, focusing instead on the admittedly broad statutory language. Our difference, then, is mostly an hermeneutical one, centering on the interpretive import of *Perreira* in ascertaining the aim of the statute.

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[18] In reviewing the legislative history, the Court placed particular emphasis on the Passed Bill Memo prepared by Governor's counsel:

> This bill attempts to reduce the cost of liability insurance by reducing the likelihood of a 'double recovery' in a liability award for items which were already compensated by insurance or by other 'collateral' sources other than a tortfeasor.

Id. at 410, 778 A.2d 429 (quoting *Passed Bill Memo to Governor Thomas H. Kean* (Dec. 7, 1987)).

In assigning minimal value to *Perreira*, the majority opinion states that the mere fact that the New Jersey statute has an impact on insurance, as settled in *Perreira*, is not enough to satisfy the "specifically directed" requirement of the saving clause. Even if, the majority argues, the New Jersey Supreme Court has identified N.J.S.A. 2A:15-97 with the insurance industry, that does not change the actual terms of the statute. *See Pilot Life*, 481 U.S. at 50, 107 S.Ct. 1549 (holding common law of bad faith not saved from preemption "[e]ven though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry"). According to the majority opinion, the collateral source statute thus resembles the Mississippi law at issue in *Pilot Life*. This analogy, however, misses the critical distinction between the two provisions.

Under the relevant state law in *Pilot Life*, punitive damages could be sought for "bad faith" in denying claims without any reasonably arguable basis for the refusal to pay. 481 U.S. at 50, 107 S.Ct. 1549. The Supreme Court determined that although Mississippi had "identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law." *Id.* "Any breach of contract," the Court observed, "and not merely breach of an insurance contract, may lead to liability for punitive damages under [the Mississippi common law of bad faith]." *Id.* Accordingly, the Court concluded that the Mississippi law did not "regulat[e] insurance" within the meaning of ERISA's saving clause. *Id.*

The holding in *Pilot Life* was premised upon the finding that "the roots of [the common law of bad faith were] firmly planted in the general principles of . . . tort

and contract law." *Id.* at 50. *Pilot Life,* contrary to the majority's reading, did not involve a situation where "a state supreme court described the law as one intended to affect the insurance industry." Majority Op. at 165. The Mississippi Supreme Court never stated that its common law of bad faith was specifically directed towards the insurance industry; it merely applied that longstanding law to the insurance context. *Pilot Life,* 481 U.S. at 49-50, 107 S.Ct. 1549. Under these circumstances, the Supreme Court quite properly held that "a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause." *Id.* at 50, 107 S.Ct. 1549.

Common sense dictates otherwise here. This case involves a *statutory enactment,* which, according to the New Jersey Supreme Court, was clearly rooted in *legislative concerns about spiraling insurance costs.* The New Jersey Supreme Court was emphatic in emphasizing insurance in its opinion:

> The effectuation of no-double-recovery [by N.J.S.A. 2A:15-97] therefore required a separate legislative decision regarding which segment of the insurance industry would be the beneficiary of that disallowance. The Legislature had two choices: to benefit health insurers by allowing repayment of costs expended on a tort plaintiff, or to benefit liability carriers by reducing the tort judgment by the amount of health care benefits received. As the legislative history reveals, the choice was made to favor liability carriers. *See Kiss v. Jacob,* 138 N.J. 278, 282 [650 A.2d 336] (1994) (stating that intent of the legislature was to control spiraling automobile-insurance costs);

> *Fayer v. Keene Corp.*, 311 N.J.Super. 200, 208, 709 A.2d 808 (App.Div.1998) (agreeing that purpose of statute is to shift burden to health industry); *Parker v. Esposito*, 291 N.J.Super. 560, 565, 677 A.2d 1159 (1996) (stating that purpose of collateral source statute is to prevent double recovery thereby giving relief from increasing costs of liability insurance); *Lusby v. Hitchner*, 273 N.J.Super. 578, 591, 642 A.2d 1055 (App.Div.1994) (stating that legislative determination "was apparently not only to prevent plaintiffs from obtaining a double recovery but also, except where PIP payments are involved, to shift the burden, at least to some extent, from the liability and casualty insurance industry to health and disability third-party payers").

Perreira, 169 N.J. at 410-11, 778 A.2d 429.

While the Supreme Court has held that "laws of general application that have some bearing on insurers do not qualify," *Miller*, 538 U.S. at 334, 123 S.Ct. 1471, the New Jersey collateral source statute presents the inverse proposition – it is a law specifically directed towards the insurance industry that has some bearing on non-insurers. As such, it "homes [sic] in on the insurance industry and does 'not just have an impact on [that] industry'." *Ward*, 526 U.S. at 368, 119 S.Ct. 1380 (quoting *Pilot Life*, 481 U.S. at 50, 107 S.Ct. 1549). Because the New Jersey statute had its genesis in specific legislative action, as opposed to general principles of tort or contract law, the majority opinion's reliance on *Pilot Life* is entirely misplaced.

For these reasons, I believe that this case more closely resembles *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct.

403, 112 L.Ed.2d 356 (1990), where the Supreme Court dealt precisely with the question of whether a state anti-subrogation law[19] was saved from preemption under § 514(b)(2)(A). There, the Court held that:

> There is no dispute that the Pennsylvania [anti-subrogation] law falls within ERISA's insurance saving clause . . . [The antisubrogation law] directly controls the terms of insurance contracts by invalidating any subrogation provisions that they contain. It does not merely have an impact on the insurance industry; it is aimed at it. This returns the matter of subrogation to state law. Unless the statute is excluded from the reach of the saving clause by virtue of the deemer clause, therefore, it is not pre-empted.

498 U.S. at 60-61, 111 S.Ct. 403 (citations omitted).

Likewise, the Sixth and Fourth Circuits reached the same conclusion in considering whether similar state antisubrogation laws regulated insurance. *See Singh*, 335 F.3d at 286 (holding that subrogation prohibition of the Maryland HMO Act is a state-law regulation of insurance); *deSoto*, 245 F.3d at 573 (holding that California's antisubrogation statute regulated insurance); *see also Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726, 729-30 (4th Cir.1992) (noting that "limits on subrogation recoveries

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[19] The relevant statute – Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law – "prohibits insurance providers from obtaining reimbursement payments from recoveries an insured receives from third parties in a motor vehicle accident." *Bill Gray Enters., Inc. Employee Health & Welfare Plan v. Gourley*, 248 F.3d 206, 213 n. 4 (3d Cir.2001).

appear to be aimed at the insurance industry, and therefore would also appear to come within the scope of the saving clause").

Contrary to the majority, I conclude that our understanding of the New Jersey collateral source statute must be informed by the New Jersey Supreme Court's interpretation. In the interpretive light cast by the Supreme Court in *Perreira*, the New Jersey collateral source statute is, in all essential respects, similar to those statutes already held to regulate insurance by the United States Supreme Court (*FMC Corp.*) and our two sister courts of appeals (*Singh* and *de Soto*).

Accordingly, I conclude that the New Jersey collateral source statute is saved from ERISA preemption.[20]

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[20] Because I would hold that the New Jersey collateral source statute is saved from ERISA preemption, I would be obliged to reach the third certified question for interlocutory appeal. That question concerns whether *Perreira*, which held that the statutory collateral source rule prohibits health insurers from filing reimbursement or subrogation liens against individual settlements or recoveries from third-party tortfeasors, applies *retroactively* to the health insurance plans at issue in this appeal.

This is a difficult issue, and more than that, the resolution of it could be outcome determinative in this appeal. As a result, I believe that the proper course for this Court to take would be to certify the issue of retroactivity to the New Jersey Supreme Court. Under New Jersey Court Rule 2:12A-1., the New Jersey Supreme Court may answer such a question if "there is no controlling appellate decision, constitutional provision or statute in this State." N.J. Ct. R. 2:12A-1. The use of certification "rests in the sound discretion of the federal courts." *Lehman Bros. v. Schein*, 416 U.S. 386, 391, 94 S.Ct. 1741, 40 L.Ed.2d 215 (1974). Such discretion, in my judgment, would be warranted here.

Because I would affirm the District Court's holding that § 514 of ERISA does not preempt N.J.S.A. 2A:15-97, I respectfully dissent from Part IV of the majority opinion, and from Part V of the majority opinion, which directs the District Court to dismiss the Insureds' claims.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 04-1224 and 04-1225

JEAN LEVINE, On behalf of herself
and all others similarly situated

v.

UNITED HEALTHCARE CORPORATION

(DC NJ 01-cv-04964)

NOREEN BOGURSKI

v.

HORIZON BLUE CROSS
BLUE SHIELD OF NEW JERSEY

(DC NJ 01-cv-05339)

BENJAMIN EDMONSON, On behalf of
Himself and All Others Similarly Situated

v.

HORIZON HEALTHCARE SERVICES, INC.,
dba Horizon Blue Cross Blue Shield of New Jersey

(DC NJ 01-cv-0582)

United Healthcare Corporation
Horizon Blue Cross Blue Shield
of New Jersey,
Appellants at No. 04-1224

JEAN LEVINE, On behalf of herself
and all others similarly situated

v.

UNITED HEALTHCARE CORPORATION

(DC NJ 01-cv-04964)

NOREEN BOGURSKI

v.

HORIZON BLUE CROSS
BLUE SHIELD OF NEW JERSEY

(DC NJ 01-cv-05339)

Jean Levine, Noreen Bogurski
*Benjamin Edmonson,
Appellants at No. 04-1225

*(Dismissed pursuant to
Court's order of 11/17/04)

On Appeal from the United States District Court
for the District of New Jersey
(D.C. Nos. 01-cv-04964, 01-cv-05339, 01-cv-05812)
District Judge: Honorable Jerome B. Simandle

Argued December 15, 2004
BEFORE: NYGAARD and GARTH, *Circuit Judges*
and POLLAK*

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* Honorable Louis H. Pollak, District Judge for the United States District Court for the Eastern District of Pennsylvania, sitting by designation.

JUDGMENT

This cause came on to be considered on the record from the United States District Court for the District of New Jersey and was argued on December 15, 2004.

On consideration whereof, it is now hereby ADJUDGED and ORDERED that the judgment of the District Court entered May 28, 2002 is AFFIRMED. The judgment of the District Court entered March 4, 2003 is REVERSED AND REMANDED with instructions to the District Court to dismiss the matter.

Each party to bear their own costs.

All of the above in accordance with the opinion of this Court.

Attest:

/s/ Kathleen Brower
Chief Deputy Clerk

DATED: March 16, 2005

285 F.Supp.2d 552

United States District Court, D. New Jersey.
Jean LEVINE, Plaintiff,
v.
UNITED HEALTHCARE CORP., Defendant.
Noreen Bogurski, Plaintiff,
v.
Horizon Blue Cross Blue Shield of New Jersey, Defendant.
Benjamin Edmonson, Plaintiff,
v.
Horizon Blue Cross Blue Shield of New Jersey, Defendant.
Nos. Civ.A. 01-4964(JBS), Civ.A. 01-5339(JBS), Civ.A. 01-5812(JBS).

Oct. 6, 2003.

Frank P. Solomon, Weitz & Luxenberg, P.C., Cherry Hill, NJ, and Donna Siegel Moffa, Lisa Rodriguez, Trujillo, Rodriguez & Richards, LLC, Haddonfield, NJ, and Natalie Finkelman Bennett, James C. Shah, Shepherd, Finkelman, Miller & Shah, LLC, Turnersville, NJ, Attorneys for Plaintiffs Levine, Bogurski, and Edmonson.

Edward A. Scallet, William F. Hanrahan, Jason H. Ehrenberg, Groom Law Group, Chartered, Washington, DC, and Theodore D. Aden, Leboeuf, Lamb, Greene & Macrae, LLP, Newark, NJ, Attorneys for Defendant United Healthcare Corporation.

Edward S. Wardell, Kelley, Wardell & Craig, LLP, Haddonfield, NJ, Attorney for Defendant Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross and Blue Shield of New Jersey.

OPINION

SIMANDLE, District Judge.

The present consolidated cases are before the Court on the motions of the parties for this Court to certify three issues for interlocutory appeal to the United States Court of Appeals for the Third Circuit pursuant to 28 U.S.C. § 1292(b). Defendants seek to appeal the Court's determination regarding two issues in the March 4, 2003 motion to dismiss decision, *see Carducci v. Aetna U.S. Healthcare*, 247 F.Supp.2d 596 (D.N.J.2003), and the plaintiffs seek to appeal the Court's determination regarding one issue in the May 28, 2002 motion to remand decision, *see Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J.2002).[1]

Defendants wish to appeal the Court's finding that (1) the antisubrogation rule included in New Jersey's collateral source statute, as interpreted by the New Jersey Supreme Court in *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001), applies to defendant health insurers because it is not conflict preempted under ERISA section 514(a) because it is "saved" as a state law that regulates insurance,[2] and (2) that the *Perreira* decision applies

[1] The pertinent previous opinions bear the name of the previous lead case, *Carducci v. Aetna U.S. Healthcare*, Civ. No. 01-4675(JBS). The *Carducci* case was closed on April 17, 2003 after this Court approved a Rule 68, Fed.R.Civ.P., Offer of Judgment which was accepted by the named plaintiffs in the *Carducci* case. *Levine v. United Healthcare Corp.*, Civ. No. 01-4964(JBS), is now the lead case in this matter.

[2] The Court considered three ERISA clauses to determine that the *Perreira* antisubrogation rule was not conflict preempted under section 514(a). Defendants only seek appeal on the savings clause issue, namely that the savings clause of section 514(b)(2)(A), which "saves"

(Continued on following page)

retroactively to plaintiffs' pre-*Perreira* health insurance plans. Plaintiffs seek to appeal the Court's finding that their unjust enrichment claims are claims for "benefits due" within the meaning of ERISA section 502(a), and therefore were properly removed to federal court.

The Court has considered the motions and has decided, for the reasons explained herein, to certify these three issues for interlocutory appeal. The Court will stay further proceedings before this Court pending resolution of this matter with the United States Court of Appeals for the Third Circuit.

I. *BACKGROUND*

The plaintiffs and defendants in these consolidated Employee Retirement Income Security Act of 1974 ("ERISA") cases seek leave to file an interlocutory appeal of three issues determined by this Court in two prior decisions, namely the motion to remand decision dated May 28, 2002, and the motion to dismiss decision dated March 4, 2003.[3] The contested issues involve complicated issues

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state laws from preemption if they govern insurance, saves the New Jersey antisubrogation rule.

Defendants do not request certification of the Court's finding that the antisubrogation rule relates to employee benefit plans under ERISA section 514(a), or that the antisubrogation rule applies here in spite of the "deemer clause" of ERISA section 514(b)(2)(B), which removes self-funded employee benefit plans from the application of state laws that regulate insurance.

[3] The procedural history of the cases is lengthy and need not be recounted in full in this background section, except as it relates to the present motions. The Court will summarize the disposition of the various cases here, though, which reduced the cases involved in the present motions to three, namely *Levine v. United Healthcare Corp.*,

(Continued on following page)

Civ. No. 01-4964(JBS); *Borgurski v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 01-5339(JBS); and *Edmonson v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 01-5812(JBS).

On January 25, 2002, the Court consolidated *Levine*, *Bogurski*, and *Edmonson* with *Carducci, et al. v. Aetna U.S. Healthcare*, No. 01-4675(JBS); *West v. Health Net of the Northeast*, Civ. No. 01-5217(JBS); and *Collins v. Oxford Health Plans*, Civ. No. 01-5237(JBS). The plaintiffs in the consolidated cases submitted a motion to remand to state court, which was denied on May 28, 2002. *See Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J.2002).

The defendants in the consolidated cases then filed a motion to dismiss, and the parties in two additional cases joined the motion. *See Bibbs v. AmeriHealth, Inc.*, Civ. No. 02-1155(JBS); *Barbour v. Cigna Corp.*, Civ. No. 02-417(JBS). The motion to dismiss was denied on March 4, 2003. *See Carducci v. Aetna U.S. Healthcare*, 247 F.Supp.2d 596 (D.N.J.2003).

Two other motions were also decided on March 4, 2003. The first was defendant Amerihealth's motion for summary judgment in *Bibbs*, asserting that there was no case or controversy because Amerihealth had never asserted a subrogation lien against the named plaintiff and had withdrawn its liens after *Perreira*. The Court granted the motion for summary judgment on March 4, 2003, and closed the *Bibbs* case. The second motion was Cigna Corp.'s motion to dismiss and compel arbitration in *Barbour*. The Court agreed that arbitration was required pursuant to the arbitration clause in the insurance agreement, granted the motion to dismiss and to compel arbitration on March 4, 2003, and closed the case.

While the motions to dismiss were pending, on August 29, 2002, defendant Aetna made an offer of judgment to the named plaintiffs in *Carducci* for the maximum monetary relief that plaintiffs could obtain for their individual claims if they won on the merits. Plaintiffs accepted the offers on August 30, 2002, and on April 16, 2003, the Court approved the judgments pursuant to Rule 23(e), Fed.R.Civ.P., and closed the case.

After defendants in the remaining cases had filed the present motion for certification of an interlocutory appeal, and the plaintiffs had filed their cross-motion, defendants Health Net and Oxford Health in *West* and *Collins* sought leave to file motions for summary judgment before this Court's decision on the present motions to assert that their plaintiffs' cases had become moot because they had withdrawn their liens and had never asserted them against the named plaintiffs. All

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regarding ERISA, a 2001 New Jersey Supreme Court case *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), and New Jersey's law of retroactivity.

The New Jersey Supreme Court, in *Perreira v. Rediger* held that New Jersey's collateral source statute, N.J.S.A. 2A:15-97,[4] includes an antisubrogation rule which prevents health insurers who have expended funds on behalf of their insureds from recouping the funds through a subrogation or reimbursement liens in the event that an insured recovers from a third-party tortfeasor. The plaintiffs, who were insureds under employee benefit health plans, assert that their plans paid health benefits for their personal injuries and then placed

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parties agreed to the adjournment of the present motions, and on May 14, 2003, Health Net and Oxford Health filed their motions for summary judgment. Plaintiffs then requested additional time for discovery, which was granted. After receiving supplemental submissions from the parties, the Court granted summary judgment in favor of Health Net and Oxford Health on August 7, 2003 and closed the *West* and *Collins* cases. *See West v. Health Net of the Northeast,* 217 F.R.D. 163 (2003).

Remaining before the Court for the present motions, therefore, are solely the *Levine, Borgurski,* and *Edmonson* cases.

[4] N.J.S.A. 2A:15-97 provides, in pertinent part:

> In any civil action brought for personal injury or death, except actions brought pursuant to . . . 39:6A-1 et seq., if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds from a life insurance policy, shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer directly by the plaintiff or by any member of the plaintiff's family on behalf of the plaintiff for the policy period during which the benefits are payable. Any party to the action shall be permitted to introduce evidence regarding any of the matters described in this act.

subrogation or reimbursement liens on their tort recoveries should they recover from a third party tortfeasor. The plaintiffs alleged that the defendant health insurers were unjustly enriched by the liens since the liens are not permitted by New Jersey's collateral source statute as interpreted by *Perreira*.

In early 2002, the Court considered motions to remand which were filed by the plaintiffs. The issue before the Court was whether the monies that plaintiffs sought – which were monies that the insurers took pursuant to the subrogation clauses in the employee benefit healthcare contracts – were "benefits due" under ERISA section 502(a)(1)(B). This Court, in an Opinion and Order dated May 28, 2002, determined that the monies were "benefits due" under section 502(a)(1)(B), so that the state law unjust enrichment claims were completely preempted by federal law and were properly removed to federal court. *See Carducci, et al. v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J.2002). Plaintiffs presently seek to file an interlocutory appeal of the Court's determination of this issue.[8]

Following the remand decision, the Court considered the consolidated defendants' motion to dismiss, which it denied on March 4, 2003. *Carducci v. Aetna U.S. Healthcare*, 247 F.Supp.2d 596 (D.N.J.2003). Defendants presently seek to file an interlocutory appeal of two of the

[8] Plaintiffs previously sought to file an interlocutory appeal of this issue in June 10, 2002. The Court denied their motion without prejudice in a July 24, 2002 Opinion and Order because plaintiffs had not shown a substantial ground for difference of opinion on the issue or that an interlocutory appeal would materially advance the ultimate termination of the litigation.

Court's findings. The first is the Court's determination that plaintiffs' claims were not conflict preempted by ERISA section 514(a) because the New Jersey antisubrogation rule is saved from ERISA preemption as a state law regulating insurance. The second is the Court's finding that the New Jersey Supreme Court's 2001 decision in *Perreira* applies retroactively to plaintiffs' pre-*Perreira* insurance policies because it represents the prior law of New Jersey.

Defendants filed their present motion to certify the two motion to dismiss issues on March 18, 2003. Plaintiffs then filed their cross-motion to certify the motion to remand issue on April 7, 2003. The Court has considered the submissions of the parties, including their oral arguments on April 24, 2003, and finds, for the following reasons, that the three issues should be certified for interlocutory appeal.

II. *DISCUSSION*

The district court has discretion, pursuant to 28 U.S.C. § 1292(b), to certify issues for interlocutory appeal to the United States Court of Appeals, provided that "exceptional circumstances" justify the departure from the general rule that appellate review is only available after a final order. 28 U.S.C. § 1292(b);[6] (*see also Coopers &*

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[6] 28 U.S.C. § 1292(b) provides, in part:

When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is a substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he shall so state in writing in

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Lybrand v. Livesay, 437 U.S. 463, 468, 98 S.Ct. 2454, 2457, 57 L.Ed.2d 351 (1978); *Hulmes v. Honda Motor Co., Ltd.*, 936 F.Supp. 195, 208 (D.N.J.1996), *aff'd*, 141 F.3d 1154 (3d Cir.1998)); *Carducci v. Aetna U.S. Healthcare*, 2002 WL 31262100 (D.N.J. Jul.24, 2002). To show that "exceptional circumstances" justify certification, the moving party bears the burden of showing (1) that the order at issue involves a controlling issue of law, which if erroneously decided, would result in reversible error on final appeal, (2) that there is substantial ground for difference of opinion about the resolution of the issue, and (3) that an immediate appeal will materially advance the ultimate termination of litigation. *See Katz v. Carte Blanche Corp.*, 496 F.2d 747, 754-55 (3d Cir.1974); *Waldorf v. Borough of Kenilworth*, 959 F.Supp. 675, 679 (D.N.J.1997).

A. *Defendants' Motion to Certify Two Issues in the March 4, 2003 Motion to Dismiss Decision*

Defendants seek certification to appeal this Court's decision regarding two legal issues in the March 4, 2003 Opinion and Order, namely: (1) that the antisubrogation rule contained in New Jersey's collateral source statute, as interpreted by the New Jersey Supreme Court in *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001), applies to defendant health insurers because it is "saved" from conflict preemption under ERISA section 514(a) as a state

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such order. The Court of Appeals which would have jurisdiction of an appeal of such action may thereupon, in its discretion, permit an appeal to be taken from such order, if application is made to it within ten days after the entry of the order: Provided, however, That application for an appeal hereunder shall not stay proceedings in the district court unless the district judge or the Court of Appeals or a judge thereof shall so order.

law that regulates insurance, and (2) that the *Perreira* decision applies retroactively to the pre-*Perreira* health insurance policies at issue in this case.

It is clear that these two issues are controlling issues in this matter and that certification of their appeal now could materially advance the termination of this litigation because an incorrect decision on either issue would result in reversible error on appeal. If, contrary to this Court's decision, the antisubrogation rule of N.J.S.A. 2A:15-97 is preempted by ERISA section 514(a), then the New Jersey antisubrogation rule would not apply to the defendant health insurers' ERISA plans and plaintiffs would be unable to assert rights arising under New Jersey law. Likewise, if the 2001 *Perreira* decision were to apply prospectively only, contrary to this Court's decision, then the plaintiffs could not obtain the protection of the *Perreira* antisubrogation rule because it would not apply to plaintiffs' pre-*Perreira* health insurance plans.

As a result, the main issue on this motion is whether defendants have shown that there are substantial grounds for difference of opinion regarding the Court's decision on these issues. The Court finds that there are, so that all three section 1292(b) requirements for interlocutory certification have been met and this Court will certify these issues for appeal.

1. Savings clause issue

There is a substantial ground for a difference of opinion on this Court's ERISA's insurance savings clause ruling, which is based on, what the United States Supreme Court has described as, "statutorily complex []"

preemption provisions. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

This Court, in its March 4, 2003 Opinion, explained then-existing law which was pertinent to the determination about whether a law "regulates insurance" under ERISA's savings clause. 29 U.S.C. § 1144(b)(2)(A);[7] *Carducci*, 247 F.Supp.2d at 614-17. The law has since changed. At the time of this Court's March 4, 2003 decision, the Supreme Court required an inquiry which "start[ed] with a common-sense view of the matter under which a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry," focusing on the "primary elements of an insurance contract[, which] are the spreading and underwriting of a policyholder's risk." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 365-66, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (quoting *Metropolitan Life Ins. Co.*, 471 U.S. at 740, 105 S.Ct. 2380; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987)). Then the court was to "test the results of the common-sense inquiry" by considering the

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[7] The savings clause "saves" state laws regulating insurance from the effect of the express preemption clause which broadly preempts state regulations of employee benefit plans, meaning that employee benefit plans may be subject to the particular state law. *See* 29 U.S.C. § 1144(a). The savings clause, states:

> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. § 1144(b)(2)(A). The deemer clause, ERISA section 514(b)(2)(B), then removes self-funded employee benefit plans from the application of state laws that regulate insurance. 29 U.S.C. § 1144(b)(2)(B).

three McCarran-Ferguson Act[6] factors which determine whether a law is an insurance law, namely whether the law targets practices that (1) have the "effect of transferring or spreading a policyholder's risk," (2) are an "integral part of the policy relationship between the insurer and the insured," and (3) are "limited to entities within the insurance industry." *Rush Prudential*, 122 S.Ct. at 2163, 122 S.Ct. 2151 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982)).

Since this Court's March 4th decision, the Supreme Court on April 2, 2003, issued its decision in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003). There, the Court decided to make a "clean break from the McCarran-Ferguson factors" because "our use of the McCarran-Ferguson case law in the ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and . . . added little to the relevant analysis." *Id.* at 1478-79. As a result, the Court enunciated two requirements needed "for a state law to be deemed a 'law . . . which regulates insurance' under section 1144(b)(2)(A)." *Id.* at 1479. First, the "state law must be specifically directed toward entities engaged in insurance." *Id.* Second, the "state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Id.*

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[6] The McCarran-Ferguson Act requires that the business of insurance be subject to state regulation, and, subject to few exceptions, provides requires that "[n]o Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance . . . " *Moran*, 122 S.Ct. at 2159 n. 4 (quoting 15 U.S.C. § 1012(b)).

This Court's decision is supportable under both the law as it existed on March 4, 2003, and the law as it exists after the *Miller* decision. First, under the law of *Rush Prudential* and *Pilot Life,* the antisubrogation rule contained in the New Jersey collateral source statute is a state law directed toward the insurance industry because, according to the *Perreira* court, it was enacted to contain "spiraling insurance costs." The McCarran-Ferguson factors also support its status as a state insurance law because the antisubrogation rule (1) spreads a policyholder's risk by ensuring that health insurers will pay for medical costs arising from an insured's tort damages, (2) is an integral part of the policy relationship between the insurer and the insured because it "requires plan providers to calculate benefit levels and premium amounts with the knowledge that they will be unable to recover monies expended for injuries caused to their insured by a third person," and (3) only affects entities within the insurance industry because the New Jersey Supreme Court found that it targets the insurance industry and only applies to the insurance industry. *Carducci,* 247 F.Supp.2d at 616-17. Second, under the law of *Miller,* the antisubrogation rule is a law regulating insurance because it (1) is specifically directed toward entities engaged in insurance as it ensures that the health insurers, and not the liability insurers, pay for tort injuries, and (2) substantially affects the risk pooling arrangement between the insurer and the insured because the Court has held that a rule which "governs whether or not an insurance company must cover [certain] claims . . . dictates to the insurance company the conditions under which it must pay for the risk it has

assumed [and] certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured." *See Miller,* 123 S.Ct. at 1478 n. 3.[9]

Even though the Court's decision is supportable, the Court recognizes that the issues involved in this case are complex and subject to debate. Defendants assert that this Court erred by isolating the antisubrogation provision from the rest of the collateral source statute. According to their argument, if the "state law" at issue here were the collateral source statute in its entirety, instead of just the antisubrogation provision within it, this Court would have erred under either savings clause analysis. Under the law of *Rush Prudential* and *Pilot Life,* the collateral source statute would not be considered an insurance law because it is not specifically directed toward the insurance industry since it "applies in every case in which a plaintiff might obtain a double recovery, even when the rule has no impact whatsoever on the insurance industry," and because, under the McCarran-Ferguson factors, it (1) may not spread a policyholder's risk because health insurers accept the risk that an insured will be injured when they

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[9] The Supreme Court in *Miller* explained that it has "never held that state laws must alter or control the actual terms of insurance policies to be deemed 'laws . . . which regulate insurance' under section 1144(b)(2)(A); it suffices that they substantially affect the risk pooling arrangement between insurer and insured." 123 S.Ct. at 1477. Thus, it found that a notice-prejudice rule, which governs whether an insurance company must cover late claims, had an effect on the risk pooling arrangement. *Id.* at 1478.

Here, the antisubrogation rule could be found to both "alter or control the actual terms of insurance policies" by requiring health insurance companies to remove the subrogation clauses from their contracts, and to govern the claims that a company must assume risk for by dictating that the health insurer cover all claims for tort injuries.

contract with the insured, regardless of the collateral source statute,[10] (2) it may not be an integral part of the policy relationship between the insurer and the insured if

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[10] Defendants argue that the collateral source statute does not spread risk because the insurance company contracted to reimburse the insured for all medical expenses and will continue to do so regardless of the effect of the collateral source statute. Their argument ignores though, that, "when looking to see if a particular practice statute acts to spread the risk," the court should "focus upon the actual risks that were transferred from the insured to the insurer and determine if the practice statute acts to alter the contractual apportionment of those risks." *Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 n. 13 (5th Cir.1993). Here, the parties contracted for the health insurer to reimburse the insured for all medical expenses subject to the health insurer's right to recover for the payments from the insured's tort settlement. The antisubrogation rule alters that contractual arrangement; now the insurer must reimburse the insured for all medical expenses, retaining no right to recover.

Moreover, defendants have supported this arguments [sic] with citations to *Tingle*, 996 F.2d at 108 and *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569 (11th Cir.1994), cases which involved insurance practice statutes, rather than mandated benefits statutes. Mandated benefits statutes "force insurers to provide coverage to all policyholders for medical expenses stemming from illnesses the insured contracted (such as cancer) . . . while under coverage of an insurance policy," and thus spread the risk of that certain illness to all policyholders in the state. *Tingle*, 996 F.2d at 108-09. "Nearly every court that has addressed the question" has found that "mandated benefits" statutes regulate insurance and are within the scope of the insurance savings clause. *Metro. Life Ins. Co. v. Mass. Travelers Ins. Co.*, 471 U.S. 724, 729, 742 n. 18, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). Insurance practice statutes, on the other hand, require insurers to follow proper insurance procedures, and thus do not "affect the apportionment of risks" because they do not change the originally contracted-for medical coverage. *Smith*, 14 F.3d at 570.

Here, the statute can be classified as a mandated benefit statute, which would be considered one that spreads risk, because it forces health insurers to provide coverage for medical expenses stemming from tortuous conduct. Pursuant to the law, policyholders statewide bear the risk of injuries arising from tortuous conduct through their health insurance premiums.

its only impact is on health insurance premiums,[11] and (3) it affects entities beyond the insurance industry because it applies in "all civil actions" to benefits from "any other source."[12] Under the law of *Miller*, defendants' arguments are basically the same, namely that the collateral source rule (1) is not specifically directed toward entities engaged in insurance because, by its express terms, it applies in "all civil actions" to amounts obtained from "any other source," and (2) does not substantially affect the risk pooling arrangement between the insurer and the insured because the insurer is required to provide benefits in the first instance regardless of the rule.

The Court can distinguish defendants' arguments and still concludes that its decision bears the correct analysis

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[11] Defendants argue that this Court's decision would lead to the conclusion that state laws that impose "stiffer licensing requirements for health care providers, sales taxes on prescription drugs, . . . or prohibit [ ] assisted suicide," would be considered insurance laws simply because they may raise insurance premiums. (Defs.' Br. at 21.) The Supreme Court, though, has held that a law which "limit[s] the type of insurance that an insurer may sell to the policyholder" regulates "an integral part of the relationship between the insurer and the policyholder." *Metropolitan Life*, 471 U.S. at 743, 105 S.Ct. 2380. If a rule "effectively creates a mandatory contract term," then it "dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship." *Cisneros*, 134 F.3d at 946. Here, the law dictates the clauses that a health insurer may insert in its insurance contracts, and thus is integral to their policy relationship, and defendants' examples are inapposite because they relate to health care rather than to the balance between premiums and benefits.

[12] Defendants' argument for this prong focuses on whether the appropriate law to consider is the collateral source statute in its entirety, which is not limited to entities within the insurance industry, or is the antisubrogation law within the collateral source statute, which is limited to entities within the insurance industry. This Court has previously detailed its reasons for considering the antisubrogation law separately.

and result. *See* notes 10, 11, 12, *supra*. However, the issue on this motion is whether there is substantial ground for debate on this issue and this Court finds that the question involved here is admittedly complicated and sufficiently close that reasonable minds could disagree with this Court's conclusion. Therefore, this Court finds that it is appropriate to certify this issue for an interlocutory appeal to the Third Circuit at this point in the litigation.

2. Issue regarding retroactivity

The Court also finds that there is a substantial ground for disagreement about this Court's March 4, 2003 finding that the 2001 *Perreira v. Rediger* decision applies retroactively to govern the terms of the pre-*Perreira* insurance policies at issue here.

The Court, in its March 4th Opinion, explained New Jersey's law regarding the retrospective application of judicial decisions. *See Carducci*, 247 F.Supp.2d at 617-19. In New Jersey, judicial decisions apply retrospectively unless the decision establishes a new rule of law that is a "sudden and generally unanticipated repudiation of a long-standing practice" and (1) the parties and the community justifiably relied on the prior rule, (2) the purpose of the new rule will not be advanced by retroactive application, and (3) retroactive application of the rule may have an adverse effect on the administration of justice. *Reuter v. Borough Council of the Borough of Fort Lee*, 167 N.J. 38, 42, 768 A.2d 769 (2001); *State v. Afanador*, 151 N.J. 41, 58, 697 A.2d 529 (1997); *Coons v. Am. Honda Motor Co.*, 96 N.J. 419, 426, 476 A.2d 763 (1984).

The Court found that the antisubrogation rule, as interpreted by the *Perreira* court, should be applied

retrospectively because the *Perreira* court found that the law of New Jersey regarding subrogation has always been reflected by the antisubrogation rule, and not by the contradictory insurance regulation considered in the opinion.[13] Thus, this Court found that the antisubrogation

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[13] The New Jersey Supreme Court issued a lengthy opinion that traced the history of the collateral source rule in New Jersey and detailed its effect on the insurance industry. *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001). The court explained that the common law collateral source rule, cited in decisions as early as 1854, allowed an injured party to recover from his tortfeasor the total amount of his damages, even if he had already recovered health insurance proceeds. *Id.* at 406, 778 A.2d 429. The theory was that a tortfeasor should not enjoy any benefit for his wrong. *Id.* Under the common law, though, the health insurance company did *not* have an equitable right to recover the amounts that it paid and the injured party could recover for his injuries twice – once from his health insurance company and once from the tortfeasor. *Id.* at 406-07, 412, 778 A.2d 429.

In the mid-1980s, states began to statutorily revise the common law collateral source rule to combat rising insurance costs (since both health insurers and liability insurers were paying for the same injuries) and to eliminate double recovery to injured parties. *Id.* at 407, 778 A.2d 429. Some states provided that the tortfeasor could reduce his payment by amounts paid by the injured party's health insurer unless the health insurer had a contractual right to subrogation or reimbursement. *Id.* at 408, 778 A.2d 429. Others provided that juries could consider and deduct moneys expended by health insurance from their tort judgment award. *Id.* Others required that tortfeasors pay the total judgment and gave health insurers the right of subrogation to recover any amounts they paid. *Id.* New Jersey provided still another option; with its enactment of N.J.S.A. 2A:15-97 in 1987, New Jersey made the "legislative determination" that the tortfeasor can reduce his payment by amounts received from collateral sources, including amounts received from the injured party's health insurance. *Id.* at 411, 778 A.2d 429. "By that action, the Legislature eliminated double recovery to plaintiffs, reduced the burden on the tortfeasors' liability carriers and left health insurers in the same position as they were prior to the enactment of N.J.S.A. 2A:15-97." *Id.* In other words, under the common law, the health insurers paid for the medical expenses of their insureds and were not able to recoup the payments via subrogation or reimbursement;

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rule was not a sudden departure from the long-standing law of New Jersey because the New Jersey Supreme Court had found that the antisubrogation rule was the long-standing law of New Jersey. *See Carducci*, 247 F.Supp.2d at 618.

Defendants have now presented additional arguments to support their argument that *Perreira* should not be applied retrospectively, arguing first that it is a sudden departure from existing law, and second that the other three requirements for prospective application have been met. While the Court's decision is still supportable in spite of the new arguments, the Court recognizes that they do

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likewise, under N.J.S.A. 2A:15-97, the health insurers were in the same position – they must pay the medical expenses and cannot recoup their payments. *Id.* Health insurance companies could not overcome this antisubrogation rule by including a contractual provision in their policies. *Id.* at 415, 778 A.2d 429.

Then, in 1993, the Department of Insurance mistakenly "allowed the inclusion of subrogation and reimbursement provisions in health insurance policies provided through the Small Employer Health Benefits Program and the Individual Health Coverage Program. N.J.A.C. 11:20[and] later, the Commissioner promulgated regulations that for the first time permitted such provisions in large group health insurance policies." *See id.*; N.J.A.C. 11:4-42:10.

In *Perreira*, the New Jersey Supreme Court considered this insurance regulation and found that it was inconsistent with the New Jersey collateral source statute, and unenforceable. *Id.* at 416, 778 A.2d 429. The health insurer involved in *Perreira* had relied on the insurance regulation, but the New Jersey Supreme Court reinstated judgments against it which barred the insurer from asserting its subrogation liens. *Id.* at 404, 418, 778 A.2d 429.

Based on this history, and on the fact that the *Perreira* court applied its own decision retrospectively, this Court decided that the *Perreira* rule was not a "sudden departure" from the long-standing law of New Jersey.

raise substantial questions that should be determined by an interlocutory appeal at this time.

Defendants first argue that the *Perreira* decision should be considered a sudden departure from existing law because this Court "overlooked a well-settled element of New Jersey's doctrine on the retroactive application of judicial decisions" which allows for prospective application when "a court renders a first-instance or clarifying decision in a murky or uncertain area of the law, or when a member of the public could reasonably have relied on a different conception of the state of the law." *SASCO v. Zudkewich,* 166 N.J. 579, 594, 767 A.2d 469 (2001) (quoting *Montells v. Haynes,* 133 N.J. 282, 298, 627 A.2d 654 (1993)); *see also Reuter v. Borough Council of Borough of Fort Lee,* 167 N.J. 38, 768 A.2d 769 (2001).[14]

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[14] In *Reuter,* the New Jersey Supreme Court applied their new interpretation of a statute prospectively because many had relied on a different interpretation. The statute in *Reuter* stated, in part, that "[t]he governing body of any municipality, by ordinance, may create and establish . . . a police force." 167 N.J. at 40, 768 A.2d 769 (quoting N.J.S.A. 40A:14-118). The municipality had then enacted an ordinance providing that police force positions could be established by resolution. *Reuter,* 167 N.J. at 40, 768 A.2d 769. When competitors contested the appointment of a deputy chief because his position was created by resolution, and not by ordinance, the New Jersey Supreme Court found that the statute required that police positions be created by ordinance. *Id.* The court further found, though, that there had been a "long-term interpretation of the law to the effect that an ordinance was not required to create new police positions" by other municipalities in New Jersey and by the Attorney General of New Jersey, and that "there has been reliance on the notion that police positions can be established by resolution," provided the resolution process was established by ordinance. *Id.* at 42-43, 768 A.2d 769. For that reason, the New Jersey Supreme Court allowed the municipality's deputy chief to remain in office, but held that "from today forward no appointment may be made

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There are substantial questions about the retrospective application of the *Perreira* decision because it, like *SASCO,* overturned a regulation that defendants relied on and considered common practice in their industry. *See* N.J.A.C. 11:4-42.10. In *SASCO,* though, unlike here, the New Jersey Supreme Court applied its decision in a "purely prospective" manner so that it would not affect the parties before it who had relied on industry practice. *SASCO,* 166 N.J. at 594, 767 A.2d 469. In *Perreira,* the Supreme Court of New Jersey recognized that the defendant insurers had relied on the erroneous insurance regulation and still applied its decision retrospectively to the insurers before it.[15]

Defendants argue, though, that this Court should not consider the fact that the *Perreira* court applied its decision retrospectively to the parties before it because New Jersey courts can follow one of four options when determining questions of retrospectivity, namely:

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to any police department position not created" by ordinance. *Id.* at 43, 768 A.2d 769.

Defendants do not explain, though, why *Reuter* should apply to this case when the *Reuter* court explicitly limited its decision to "today forward" and the *Perreira* court applied its decision to the parties before it. The court was clearly aware of the *Reuter* decision, which was issued on March 29, 2001, when it issued its *Perreira* decision on June 26, 2001.

[15] The court specifically recognized that the insurers involved in *Perreira* had included reimbursement provisions in their contract in reliance on industry practice and the New Jersey administrative regulation permitting reimbursement. *Perreira,* 169 N.J. at 415, 778 A.2d 429. Even so, the court found that the health insurers could not recover pursuant to the reimbursement provisions because New Jersey statutory law had established an antisubrogation scheme that "the Commissioner was not free to alter" with a regulation. *Id.* at 416, 778 A.2d 429.

> (1) make the new rule of law purely prospective, applying it only to cases whose operative facts arise after the new rule is announced;
>
> (2) apply the new rule to future cases and to the parties in the case announcing the new rule, while applying the old rule to all other pending and past litigation;
>
> (3) grant the new rule limited retroactivity, applying it to cases in (1) and (2) as well as to pending cases where the parties have not yet exhausted all avenues of direct review; and
>
> (4) give the new rule complete retroactive effect, applying it to all cases, even those where final judgments have been entered and all avenues of direct review exhausted.

Coons, 96 N.J. at 425, 476 A.2d 763. The approach taken depends largely on "the court's view of what is just and consonant with public policy in the particular situation presented." *Id.* (quoting *State v. Nash*, 64 N.J. 464, 469, 317 A.2d 689 (1974)). Here, therefore, the New Jersey Supreme Court may have intended that option (2) be followed, in other words, that the *Perreira* decision be applied retrospectively to the *Perreira* parties, but not be applied to other pending cases.

Although this Court continues to believe that the *Perreira* court spoke definitively to apply its antisubrogation decision retrospectively, the Court finds that defendants have shown that its decision regarding the longstanding law of New Jersey and whether *Perreira* was a departure from that law, are close issues that should be clarified at this point.

Defendants also argue that there are substantial questions about this Court's findings on the other three factors required to justify prospective application.[16] For the first prong, they argue that they justifiably relied on the prior law of New Jersey when they relied on the insurance commissioner's regulation. This raises a question because the insurance companies had reason to believe that the insurance regulation was appropriate since administrative regulations are generally accorded a high degree of deference, *see Perreira*, 169 N.J. at 415, 778 A.2d 429.[17] For the second prong, defendants argue that the purpose of the *Perreira* rule will not be advanced by retroactive application because requiring the health insurers to pay plaintiffs for amounts taken will not "shift the burden of health costs away from liability insurers and onto health insurers" because the money is being returned to the plaintiffs and not to the liability insurers.[18] This argument, though

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[16] As explained *supra*, prospective application is only appropriate if the decision is a sudden departure from long-standing law *and* (1) the parties and the community justifiably relied on the prior state law, (2) the purpose of the new law will not be advanced by retroactive application, and (3) the retroactive application of the new law may have an adverse effect on the administration of justice. *See Reuter*, 167 N.J. at 42, 768 A.2d 769; *Coons*, 96 N.J. at 426, 476 A.2d 763.

[17] This Court based its holding that they did not rely on the prior law of the state because the *Perreira* court found that the regulation did not reflect the prior law of the state. The prior law, indeed, was the 1987 enactment of N.J.S.A. 2A:15-97, and not the subsequent insurance regulations in N.J.A.C. 11:4-42:10, *supra*. Given the antisubrogation provisions of the statute, any reliance on the contrary regulation is weak.

[18] Defendants did not present this argument in support of their motion to dismiss. Instead, there they argued that the purpose of the *Perreira* rule would be hampered by retroactive application because it would allow insureds to double recover by allowing them to retain amounts recovered from liability insurers while receiving amounts from

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valid, does assume that the liability insurers paid plaintiffs for the medical expenses that plaintiffs received health insurance coverage for, and the plaintiffs here have asserted that they were injured because they were not compensated for their injuries by either the liability insurer or the health insurer which, though it originally compensated them, took the compensation back via the reimbursement or subrogation lien.[19] For the third prong, defendants argue that there are substantial questions with the Court's decision because retroactive application of *Perreira* would have an adverse effect on the administration of justice

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health insurers. The Court found that this argument assumed that the insureds recovered from the liability insurance companies for their medical expenses in the first place, a fact that plaintiffs denied and that was contradicted by the language of the collateral source statute that "any benefits" for injuries received "from any other source . . . shall be deducted" from the tortfeasor's (or liability insurer's) payment. *See* N.J.S.A. 2A:15-97. Therefore, if the liability insurers did in fact deduct amounts that the plaintiffs received from the health insurers, and the health insurers took amounts they paid, retroactive application was needed to ensure that the plaintiffs were fully compensated.

[19] Defendants admit that this Court found that there are questions of fact concerning whether the plaintiffs recovered the cost of the medical expenses from the liability insurers. They argue, that even if the plaintiffs did not receive from the liability insurers, it would "not change the equation" because then, the liability insurers must have thought that the insurance regulation permitting subrogation and reimbursement was not valid, because they otherwise would have calculated their settlement offers based on it. (Defs.' Br. at 29 n. 3.) Then, if they thought that the regulation was invalid, it "would logically have had no adverse impact on liability insurance premiums [and] returning the money now to plaintiffs would do nothing to advance the statutory purpose." (*Id.*) This argument again ignores the effect of the insurance regulation on plaintiffs. Even if liability insurance premiums were not affected by the regulation, the plaintiffs, if not compensated by the liability insurers for their medical expenses but forced to reimburse their health insurers for the medical expenses, would bear the cost of their own medical expenses.

because it will raise a "judicial mare's nest" of factual issues in every case about whether *Perreira* applies or whether the voluntary payment doctrine removes a prior settlement agreement from its reach.[20] It is true that the administration of justice may become more complicated if *Perreira* is applied retrospectively, but it is also clear that justice may require retrospective application to ensure that plaintiffs' medical expenses are compensated.

While the Court has considered defendants' arguments and has pointed out their weaknesses, the Court acknowledges that the issues here are complex and subject to debate, especially because of defendants' reliance on the permissive insurance regulation. "Questions of retroactivity for years have been considered 'among the most difficult' problems that engage the attention of the courts, both state and federal." *Coons*, 96 N.J. at 424-25, 476 A.2d 763 (quoting *Chicot County Drainage Dist. v. Baxter State Bank*, 308 U.S. 371, 374, 60 S.Ct. 317, 84 L.Ed. 329 (1940)). Thus, this Court finds that the question of retroactivity here is a close issue that is subject to debate and should be certified for an appeal at this time in the litigation.

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[20] In their motion to dismiss papers, defendants argued that retroactive application would have an adverse effect on justice because it would allow injured parties to undo settlement agreements entered into with their health insurance companies to satisfy the subrogation liens the health insurance companies had asserted on their tort judgments. The Court discounted this argument, explaining that prior settlement agreements could still be enforced under New Jersey law if the elements of the voluntary payment doctrine were satisfied.

B. *Plaintiffs' Motion to Certify the May 28, 2002 Order Denying Their Motion to Remand*

Plaintiffs have not opposed defendants' motion to certify this Court's March 4, 2003 order; instead, they seek certification at the same time of this Court's May 28, 2002 decision which denied their motion to remand based on the Court's finding that plaintiffs' claims, although expressed under state law, are in fact for "benefits due" under the terms of their ERISA plan, and thus must be considered in federal court. *See Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J.2002); 29 U.S.C. § 1132(a)(1)(B).[21]

Plaintiffs previously sought certification of the May 28, 2002 Opinion and Order, which was denied without prejudice in this Court's July 24, 2002 Opinion and Order. *See Carducci v. Aetna U.S. Healthcare*, 2002 WL 31262100 (D.N.J. Jul. 24, 2002). There, the Court found that the issue decided in the motion was a controlling question of law, but that plaintiffs failed to show that there was a substantial ground for disagreement about the issue or that certification of the issue would advance the ultimate termination of the litigation.[22] Plaintiffs assert that the

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[21] ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides, in relevant part:

> A civil action may be brought –
>
> (1) by a participant or beneficiary – . . .
>
> (B) *to recover benefits due to him under the terms of his plan*, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

[22] As noted *supra*, for exceptional circumstances to justify certification, the moving party must show (1) that the order at issue involves a controlling issue of law, which if erroneously decided, would result in reversible error on final appeal, (2) that there is substantial ground for

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calculus has changed at this stage of the litigation and that this issue should now be certified for interlocutory appeal. This Court agrees and will certify the issue.

Again the issue here revolves around whether there are substantial grounds for disagreement on this issue. It is again clear that the issue presented for review is a controlling question of law because if, contrary to this Court's decision, plaintiffs' claims are not claims for benefits due under their ERISA plans within the meaning of ERISA section 502(a)(1)(B), then this Court lacks federal jurisdiction over the action. Likewise, it is clear that certifying this issue now, in conjunction with the certification of defendants' appeal, would materially advance the ultimate termination of the litigation by providing the Third Circuit with all pertinent, and disputed, issues at once.

The principal issue, thus, is whether there are substantial grounds for debate about this Court's "benefits due" decision. Plaintiffs argue that "the situation now is very different than at the time of their original § 1292(b) motion" because subsequent decisions have shown that "substantial ground for difference does indeed exist with regard to this important jurisdictional issue."[23] (Pls.' Br. at

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difference of opinion about the resolution of the issue, and (3) that an immediate appeal will materially advance the ultimate termination of litigation. *See Katz v. Carte Blanche Corp.*, 496 F.2d 747, 754-55 (3d Cir.1974).

[23] In the Court's prior section 1292(b) decision, it found that plaintiffs had shown personal disagreement with the Court's decision, but not a substantial ground for difference of opinion about it. Plaintiffs had not pointed to any precedent which indicated that there was a split of authority on the issue. To the contrary, the Court found that its decision aligned with the decisions of other courts which had considered

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4 (citing *Arana v. Ochsner Health Plan, Inc.*, 302 F.3d 462 (5th Cir.2002), rehearing *en banc* granted, 319 F.3d 205 (2003)); *McKandes v. Blue Cross and Blue Shield Assoc.*, 243 F.Supp.2d 380 (D.Md.2003); *Popoola v. MD-Individual Practice Assoc.*, 244 F.Supp.2d 577 (D.Md.2003)).

The Court finds that these subsequent cases can be distinguished from the present case,[24] but that they still

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the same issue. *See Carducci*, 2002 WL 31262100 at *2 (citing *Franks v. Prudential Health Care Plan, Inc.*, 164 F.Supp.2d 865, 873 (W.D.Tex.2001); *Riemer v. Columbia Medical Plan, Inc.*, 1997 WL 33126252, at *1-2 (D.Md. Mar.28, 1997); *Kaszula v. Parker*, 1997 WL 106267 (N.D.Ill. Feb.13, 1997)).

[24] In *Arana*, the health insurance company had not filed a formal claim for subrogation or reimbursement, as defendants did here, so the plaintiff's suit was solely for a declaration that the company was not entitled to do so. 302 F.3d at 470. The Fifth Circuit, in a decision that the court has since agreed to rehear, found that the claim was not one for benefits due because the plaintiff did not seek additional benefits from the health insurer. *Id.* The court specifically distinguished this Court's decision in *Carducci*, stating that the plaintiff's "case therefore does not present a situation . . . in which a participant or beneficiary seeks to recover benefits she claims were wrongly reimbursed to an ERISA plan out of funds recovered by a third party, *e.g. Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796, 803 (D.N.J.2002)." *Id.* at 470 n. 9.

In *McKandes*, the plaintiff had paid amounts to her health insurer to settle a subrogation lien, but then filed her complaint seeking only class relief for persons who had "been notified by [the defendant health insurer] that it had a lien against or a subrogation interest in any monies that the members or insureds had received or would receive from a third party." *McKandes*, 243 F.Supp.2d at 384. The court, following *Arana*, found that the action was not one to seek "benefits due" because plaintiff also sought only declaratory relief.

In *Popoola*, the plaintiff paid a settlement to her health insurer to satisfy a subrogation lien and then filed suit alleging that the health insurer was "unjustly enriched by its practice of claiming and receiving asserted liens against and subrogation interests in monies that its members and insureds received from third parties." 244 F.Supp.2d at 579. The defendants asserted that the action was to "enforce rights"

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show that the issue here is complex, controversial, pivotal to this Court's subject matter jurisdiction, and subject to debate. Therefore, the Court will also certify this issue for interlocutory appeal.

III. CONCLUSION

This Court has considered the motions of the parties seeking the certification of three issues for interlocutory appeal to the United States Court of Appeals for the Third Circuit and has found, for the foregoing reasons, that the three issues, namely

> (1) whether the antisubrogation rule contained in N.J.S.A. 2A:15-97, as interpreted by the New Jersey Supreme Court in *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), applies to defendant health insurers because it is not conflict preempted under ERISA section 514(a) because it is "saved" as a state law that regulates insurance;
>
> (2) whether *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), applies retroactively to plaintiffs' pre-*Perreira* health insurance plans; and
>
> (3) whether plaintiffs' unjust enrichment claims for monies taken pursuant to subrogation and reimbursement provisions in their ERISA health plans are claims for "benefits due" within the meaning of ERISA section 502(a);

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under the benefit plan, instead of, as here, one seeking "benefits due." *Id.* at 580. Thus, the court did not consider whether the claim was a "claim for benefits." Instead, the court found that a case challenging a provision in the health plan was not an action to enforce a provision in a health plan. *Id.* at 581.

are controlling issues of law, around which there are substantial grounds for disagreement which should be resolved at this stage in the litigation. Thus, this Court will certify these three issues for appeal and will stay further action in these three consolidated cases pending the resolution of this matter before the United States Court of Appeals for the Third Circuit.

The accompanying Order is entered.

ORDER CERTIFYING QUESTIONS FOR INTERLOCUTORY APPEAL

This matter having come before the Court on the motion of defendants for this Court to certify for interlocutory appeal two issues determined in this Court's March 4, 2003 decision denying defendants' motion to dismiss, [Docket Item 27-1], and the motion of plaintiffs for this Court to certify for interlocutory appeal one issue determined in this Court's May 28, 2002 decision denying plaintiffs' motion to remand, [Docket Item 29-1], and the Court having considered the submissions of the parties and their oral arguments on April 24, 2003, and having found, for the reasons expressed in an Opinion of today's date, that the issues should be certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b);

IT IS this ___ day of October, 2003 hereby:

ORDERED that defendants' motion for this Court to certify for interlocutory appeal two issues determined in this Court's March 4, 2003 decision denying defendants' motion to dismiss, [Docket Item 27-1], be, and hereby is, ***GRANTED***, and the following two issues are certified for interlocutory appeal:

(1) whether the antisubrogation rule contained in N.J.S.A. 2A:15-97, as interpreted by the New Jersey Supreme Court in *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), applies to defendant health insurers because it is not conflict preempted under ERISA section 514(a) because it is "saved" as a state law that regulates insurance; and

(2) whether *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), applies retroactively to plaintiffs' pre-*Perreira* health insurance plans; and

IT IS FURTHER ORDERED that plaintiffs' motion for this Court to certify for interlocutory appeal one issue determined in this Court's May 28, 2002 decision denying plaintiffs' motion to remand, [Docket Item 29-1], be, and hereby is, ***GRANTED*** and the following issue is certified for interlocutory appeal:

whether plaintiffs' unjust enrichment claims for monies taken pursuant to subrogation and reimbursement provisions in their ERISA health plans are claims for "benefits due" within the meaning of ERISA section 502(a); and

IT IS FURTHER ORDERED that proceedings in *Levine v. United Healthcare Corp.,* Civil No. 01-4964(JBS); *Bogurski v. Horizon Blue Cross Blue Shield of New Jersey,* Civil No. 01-5339(JBS); and *Edmonson v. Horizon Blue Cross Blue Shield of New Jersey,* Civil No. 01-5812(JBS), be, and hereby are, ***STAYED*** pending disposition of these issues before the United States Court of Appeals for the Third Circuit.

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247 F.Supp.2d 596

United States District Court, D. New Jersey.
Caroline CARDUCCI and David Labinski, Plaintiffs,

v.

AETNA U.S. HEALTHCARE, Defendant.
Jean Levine, Plaintiff,

v.

United Healthcare Corp., Defendant.
Carole West, Plaintiff,

v.

Health Net of the Northeast, Defendant.
David Collins, Plaintiff,

v.

Oxford Health Plans, Defendant.
Noreen Bogurski, Plaintiff,

v.

Horizon Blue Cross Blue Shield of New Jersey, Defendant.
Benjamin Edmonson, Plaintiff,

v.

Horizon Blue Cross Blue Shield of New Jersey, Defendant.
Dellece L. Barbour, Plaintiff,

v.

CIGNA Healthcare of New Jersey, Inc., Defendant.
William Bibbs, Plaintiff,

v.

AmeriHealth, Inc., Defendant.

Civil Action Nos. 01-4675 (JBS), 01-4964(JBS), 01-5217(JCL), 01-5237(JWB), 01-5339(JBS), 01-5812(JBS), 02-417(JBS), 02-1155(JBS).

March 4, 2003.

Frank P. Solomon, Esquire, Weitz & Luxenberg, P.C., Cherry Hill, NJ, and Donna Siegel Moffa, Esquire, Lisa Rodriguez, Esquire, Nicole M. Miles, Esquire, Trujillo, Rodriguez & Richards, LLC, Haddonfield, NJ, and Carl D. Poplar, Esquire, Jeffrey Ahren, Esquire, Poplar & Eastlack, Turnersville, NJ, and Roberta D. Liebenberg, Esquire, Fine, Kaplan And Black, R.P.C., Philadelphia, PA, and Marc H. Edelson, Hoffman & Edelson, Doylestown, PA, and Natalie Finkelman Bennett, Esquire, James C. Shah, Esquire, Shepherd, Finkelman, Miller & Shah, LLC, Turnersville, NJ, and Scott R. Shepherd, Esquire, Shepherd, Finkelman, Miller & Shah, LLC, Media, PA, and John W. Trimble, Jr., Esquire, Morrison & Trimble, LLC, Turnersville, NJ, and Mitchell A. Toups, Esquire, Weller, Green, Toups & Terrell, LLP, Beaumont, TX, for Plaintiffs Carducci, Labinski, Levine, West, Collins, Bogurski, Edmonson, and Barbour.

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Edward S. Wardell, Esquire, Kelley, Wardell & Craig, LLP, Haddonfield, NJ, for Defendant Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross and Blue Shield of New Jersey and for Defendant Aetna U.S. Healthcare.

Edward A. Scallet, Esquire, William F. Hanrahan, Esquire Jason H. Ehrenberg, Esquire, Groom Law Group, Chartered, Washington, DC, and Theodore D. Aden, Esquire, Leboeuf, Lamb, Greene & Macrae, LLP, Newark, NJ, for Defendant United Healthcare Corporation.

B. John Pendleton, Jr., Esquire, McCarter & English, LLP, Newark, NJ, for Defendant Health Net of the Northeast, Inc.

William J. O'Shaughnessy, Esquire, McCarter & English, LLP, Newark, NJ, for Defendant Oxford Health Plans, Inc.

Douglas Arpert, Esquire, Norton, Arpert, Sheehy & Higgins, P.C., West Patterson, NJ, and Brian D. Boyle, Esquire, Martha Dye, Esquire, William J. Stuckwisch, Esquire, O'Melveny & Myers, LLP, Washington, DC, for Defendant CIGNA HealthCare of New Jersey, Inc.

Thomas S. Biemer, Esquire, John J. Higson, Esquire, Dilworth Paxson, LLP, Cherry Hill, NJ, for Defendant AmeriHealth, Inc.

SIMANDLE, District Judge:

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Under New Jersey law, a health insurer which paid benefits on behalf of an insured may not recoup those funds through a subrogation or reimbursement lien upon the insured's recovery from a third-party tortfeasor, and any such subrogation provision in a New Jersey insurance contract is therefore void. *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001) (interpreting N.J.S.A. 2A:15-97). The principal issues in the present consolidated cases involve whether this prohibition of subrogation arising at state law applies to the health insurance contracts of New Jersey employee benefit plans governed under federal law through the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, and thus whether the plaintiff-insureds are entitled to repayment of such subrogated funds, or whether such a claim is preempted by ERISA section 502(a), 29 U.S.C. § 1132(a) (complete preemption) or by ERISA section 514(a), 29 U.S.C. § 1144(a) (conflict preemption).

The present motion to dismiss thus requires the Court to consider the doctrines of complete preemption and conflict preemption under ERISA. Congress passed ERISA to "safeguard the establishment, operation, and administration of employee benefit plans," and included the statute's two preemption provisions to ensure that the federal ERISA statute would set "minimum standards [to] assur[e] the equitable character of such plans and their financial soundness." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (quoting 29 U.S.C. § 1001(a)). By preempting many state regulations, ERISA makes clear that the regulation of employee benefit plans is "exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981).

Complete preemption arises under ERISA section 502(a)'s civil enforcement provision; it completely preempts state law claims within its scope and converts them into federal ERISA claims. Conflict preemption arises under ERISA section 514(a); it expressly preempts any state law which relates to an ERISA plan unless the law "regulates insurance, banking, or securities."

The matter is presently before the Court on seven motions to dismiss by defendants in each of the seven consolidated actions other than *Carducci* itself.[1] [Docket Items 40-1, 42-1, 48-1, 50-1, 50-2, 52-1, and 54-1 in *Carducci, et al. v. Aetna U.S. Healthcare,* No. 01-4675.] The consolidated defendants assert that plaintiffs' complaints should be dismissed pursuant to Fed.R.Civ.P. 12(b)(6) for failure to state a claim upon which relief may be granted because their state law claims are completely preempted and conflict preempted by ERISA.

The Court has considered the submissions of all of the parties and has decided that defendants' motions to dismiss on the basis of complete and conflict preemption must be denied. The Court will then consider, and deny, three additional arguments presented for dismissal, namely whether the 2001 *Perreira* case on which the claims are based should apply retrospectively, whether certain claims should be barred by the voluntary payment doctrine, and whether certain plaintiffs have standing to

---

[1] In *Carducci*, plaintiffs Caroline Carducci and David Labinski have accepted the offer of judgment by defendant Aetna U.S. Healthcare under Rule 68, Fed.R.Civ.P., in October, 2002, and only a motion for attorney's fees remains pending in that suit. This Opinion, therefore, addresses only the dispositive motions filed in *Levine*, *West*, *Collins*, *Bogurski*, *Edmonson*, *Barbour*, and *Bibbs*.

bring suit. Then, the Court will consider, and will grant, the motion for summary judgment brought in *Bibbs*.

I. *BACKGROUND*

On January 28, 2002, this Court granted the motion of defendants in six cases to consolidate their actions for the limited purpose of considering motions for remand and motions to dismiss. As a result, the cases of *Levine v. United Healthcare Corp.*, Civ. No. 01-4964(JBS); *West v. Health Net of the Northeast*, Civ. No. 01-5217(JCL); *Collins v. Oxford Health Plans*, Civ. No. 01-5237(JWB); *Borgurski v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 01-5339(JBS); and *Edmonson v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 01-5812(JBS), were consolidated under the caption of the earliest docket, *Carducci, et al. v. Aetna U.S. Healthcare*, No. 01-4675(JBS). Parties in another action, *Bibbs v. AmeriHealth, Inc.*, Civ. No. 02-1155(JBS), agreed to have their case consolidated under the *Carducci* docket for purposes of the remand motion; they have since joined the present motion to dismiss.[2] Parties in another action, *Barbour v. CIGNA Corp.*, Civ. No. 02-417(JBS), agreed to consolidate under the *Carducci* docket for purposes of the motion to dismiss if defendant's motion to compel arbitration is not granted.[3]

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[2] Defendant AmeriHealth concurrently filed a motion for summary judgment which is specific to the *Bibbs* action. [Docket Item 48-1 in *Carducci*.] The Court will consider this summary judgment motion in section II(D), *infra*.

[3] The motion to compel arbitration and to dismiss in the *Barbour* action was granted on March 4, 2003. Therefore, this Court will dismiss the present *Barbour* conditional motion to dismiss, [Docket Item 52-1 in the *Carducci*, No. 01-4675 docket], as moot.

The present cases were consolidated because their motions to remand and motions to dismiss all dealt with similar issues arising under the Employee Retirement Income Security Act of 1974 ("ERISA"). Each was originally filed as a class action complaint in New Jersey Superior Court based on *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001), where the New Jersey Supreme Court held that, under New Jersey statute N.J.S.A. 2A:15-97, a health insurer who expended funds on behalf of an insured may not recoup the funds through a subrogation or reimbursement liens if the insured recovers from a third-party tortfeasor. In the present cases, each plaintiff was insured under an employee benefit health plan which paid health benefits due to plaintiff's personal injuries, and where the plaintiff later recovered from a third party tortfeasor in connection with such injuries, the defendant insurers sought to enforce the plans' subrogation clauses to recoup from these plaintiffs the sums previously paid to them under the health benefit plans, by attaching subrogation or reimbursement liens to the plaintiffs' tort recoveries. Each plaintiff brought suit against his or her health insurer, alleging that it was unjustly enriched by subrogation and reimbursement liens placed on their personal injury lawsuit settlements.

On January 25, 2002 and on April 4, 2002, this Court heard oral argument on the remand motions. The issue was whether the monies that plaintiffs sought – which were monies that the insurers took pursuant to the subrogation clauses in the employee benefit healthcare contracts – were "benefits due" under ERISA section 502(a)(1)(B). This Court, in an Opinion and Order dated May 28, 2002, determined that the monies were "benefits due" under section 502(a)(1)(B), so that the state law unjust enrichment claims

were completely preempted by federal law and were properly removed to federal court. *See Carducci, et al. v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J.2002).[4]

In the May 28, 2002 Opinion and Order on the remand motions, this Court did not determine the issues presented in the present motions to dismiss, namely whether plaintiffs' state law unjust enrichment claims must be dismissed as completely preempted under section 502(a)(1)(B), or must be dismissed as conflict preempted under section 514(a). The Court will now consider these issues.

II. *DISCUSSION*

A. *Motion to Dismiss Standard of Review*

The Court must deny a Rule 12(b)(6) motion to dismiss for failure to state a claim upon which relief may be granted "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S.Ct. 1683, 40 L.Ed.2d 90 (1974). A district court must accept any and all reasonable inferences derived from the facts and must view all allegations in the complaint in the light most favorable to the plaintiff. *See Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S.Ct. 1683, 40

[4] Plaintiffs filed a motion to alter or amend the May 28, 2002 Opinion and Order to allow them to seek an interlocutory appeal of the decision. This Court treated the motion as seeking certification of an interlocutory appeal to the United States Court of Appeals for the Third Circuit pursuant to 28 U.S.C. § 1292(b), and, in a July 24, 2002 Opinion and Order, denied the motion without prejudice because the plaintiffs had not met their burden of showing a substantial ground for difference of opinion on the issue or that an interlocutory appeal would materially advance the ultimate termination of the litigation.

L.Ed.2d 90 (1974); *Jordan v. Fox, Rothschild, O'Brien & Frankel*, 20 F.3d 1250, 1261 (3d Cir.1994).

The plaintiff does not need to plead evidence or plead the facts that are the basis for the claim. *Bogosian v. Gulf Oil Corp.*, 561 F.2d 434, 446 (3d Cir.1977); *In re Midlantic Corp. Shareholder Litig.*, 758 F.Supp. 226, 230 (D.N.J.1990). The question before the court is not whether plaintiffs will ultimately prevail; rather, it is whether they can prove any set of facts in support of their claims that would entitle them to relief. *Hishon v. King & Spalding*, 467 U.S. 69, 73, 104 S.Ct. 2229, 81 L.Ed.2d 59 (1984). Therefore, in deciding a motion to dismiss, a court should look to the face of the complaint and decide whether, taking all of the allegations of fact as true and construing them in a light most favorable to the nonmovant, plaintiff's allegations state a legal claim. *Markowitz*, 906 F.2d at 103.

B. *Motion to Dismiss Analysis*

The present motions require the Court to consider ERISA preemption. The Court has previously determined that plaintiffs' claims, although pleaded under state law, are section 502(a)(1)(B) claims for benefits, and therefore that these claims lie within the exclusive federal jurisdiction of section 502(a)(1)(B). *See Carducci*, 204 F.Supp.2d at 803-04. The Court will now consider whether plaintiffs' claims must be dismissed because they are completely preempted, or whether plaintiffs' claims must be dismissed because they are conflict preempted under section 514(a).

1. *Complete Preemption Dismissal under Section 502(a)*

Based on this Court's previous determination that plaintiffs' claims are within the scope of jurisdiction described by section 502(a)(1)(B), defendants argue that this Court must dismiss them under section 502(a)(1)(B) for three reasons: (1) plaintiffs have only alleged state law causes of action and not section 502(a)(1)(B) claims, (2) plaintiffs have not joined the appropriate defendants, and (3) plaintiffs have not exhausted their plans' administrative remedies. This Court will consider each reason in turn and will find that they do not provide a basis for dismissal.

(a) Failure to allege ERISA cause of action

Defendants first seek dismissal because plaintiffs' complaints do not allege ERISA section 502(a)(1)(B) causes of action. They argue that because section 502(a)(1)(B) only allows a civil action "to recover benefits due . . . under the terms of [a] plan," plaintiffs needed to explicitly seek such benefits. Because plaintiffs, in their complaints, seek recovery based solely on state law, defendants argue that there is no section 502(a)(1)(B) action for this Court to consider. This Court disagrees and finds that its prior determination that plaintiffs' state law claims were 502(a)(1)(B) claims for benefits indeed allows the Court to consider them as 502(a)(1)(B) claims for benefits.

Congress provided for complete preemption of state law claims in ERISA section 502(a). *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). Complete preemption occurs when Congress passes a law that "so completely pre-empt[s] a

particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Id.* at 63, 107 S.Ct. 1542. In effect, the complete preemption transforms the claim that is within the "select group" into a claim that is "federal in character." *Darcangelo v. Verizon Communications Inc.*, 292 F.3d 181, 187 (4th Cir.2002).

The complete preemption provided for in ERISA, therefore, means that when a plaintiff files a complaint that contains a state law claim that is within the scope of ERISA section 502(a), the claim is transformed into an ERISA section 502(a) federal claim. *Id.* The cause of action may then be removed to federal court without violating the well-pleaded complaint rule because the complaint contains the transformed federal claim on its face. *Id.* At that point, the federal court can either treat the claim as a federal claim under section 502(a), *id.* at 195, or can dismiss the complaint without prejudice to refiling a complaint that alleges an ERISA claim for benefits, *Miller v. Aetna Healthcare*, No. 01-2443, 2001 WL 1609681 at *2 (E.D.Pa. Dec.12, 2001).

The United States District Court for the Eastern District of Pennsylvania has found that "[w]hen a plaintiff's claims are completely preempted by ERISA, dismissal without prejudice to assert an ERISA claim is an appropriate course." *See Miller*, 2001 WL 1609681 at *2. While there likely are many situations where a dismissal would be appropriate to allow the plaintiffs to replead their claims as ERISA claims, this Court finds that it is more appropriate in this case to treat the claims as ERISA claims.

The principal reason for this Court's decision is based on the extensive motion practice already engaged in by the parties.

In *Miller*, the Court considered the motion to remand and the motion to dismiss simultaneously. Here, defendants have been aware that plaintiffs' claims are section 502(a) "claims for benefits" since this Court's decision in May 2002 on the remand motions, and have been aware that the basis for the claims for benefits are the reimbursement and subrogation provisions in their health insurance contracts. For purposes of this motion to dismiss, the defendants treated the claims as claims for benefits under section 502(a), stating that "it is instructive to consider the complaint as a claim for benefits." (Defs.' Br. in *Levine* at 10.) In view of this procedural history, the Court will not dismiss the present complaints and require the plaintiffs to refile complaints which allege section 502(a) claims, but will treat the complaints as alleging state claims now transformed into federal ERISA claims for benefits.

(b) Failure to plead plan as section 502(a)(1)(B) defendant

Defendants next argue that this Court must dismiss because they are not the proper defendants. Defendants first argue that plaintiffs may only proceed against employee benefit plans under section 502(a)(1)(B). (Defs.' Br. in *Levine* at 11.) Alternatively, defendants argue that even if plaintiffs could proceed against the administrators of their plans, plaintiffs never alleged that defendants were plan administrators in their complaints. (Defs.' Reply Br. in *Levine* at 6 n. 3.)

Whether a plan administrator may be liable under section 502(a)(1)(B) is an issue that has divided the courts. *See Hall v. Lhaco, Inc.*, 140 F.3d 1190, 1194 (8th Cir.1998) (citing cases). Some courts find that "ERISA permits suits to recover benefits only against the plan as an entity" by linking section 502(a)(1)(B) which allows "a civil action . . . to recover benefits due . . . under the terms of [a] plan" with section 502(d) which states that:

> An *employee benefit plan* may sue or be sued under this subchapter as an entity. . . . Any money judgment under this subchapter against an *employee benefit plan* shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1490 (7th Cir.1996) (citing *Gelardi v. Pertec Computer Corp.*, 761 F.2d 1323, 1324-25 (9th Cir.1985)) (emphasis added); *see also Guiles v. Metropolitan Life Ins. Co.*, No. 00-5029, 2002 WL 229696 (E.D.Pa. Feb.13, 2002). Other courts have found that the statutory language allows a plaintiff to proceed against an employee benefit plan, but does not limit the plaintiff to suits against plans. *See Hamilton v. Allen-Bradley Co.*, 244 F.3d 819, 824 (11th Cir.2001); *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469 (9th Cir.1994); *see also Vaughn v. Metropolitan Life Ins. Co.*, 87 F.Supp.2d 421, 425 (E.D.Pa.2000). Such courts find that a plaintiff may proceed against the plan or against the plan's administrator. *Id.* The Third Circuit has not determined whether a plaintiff may bring suit against a plan administrator under section 502(a)(1)(B).

This Court will allow suit against plan administrators under section 502(a)(1)(B) for two reasons. First, the Third Circuit has allowed suit against entities other than benefit plans under section 502. In *Curcio v. John Hancock Mutual Life Ins. Co.*, 33 F.3d 226 (3d Cir.1994), the Third Circuit considered whether a plaintiff could bring suit against a party other than the plan under section 502(a)(3)(B)'s equitable relief provision,[6] and concluded that the plaintiff could proceed against a plan administrator who was also a fiduciary. In *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433 (3d Cir.1997), the Third Circuit never mentioned the present issue, but considered a 502(a)(1)(B) claim against a plan administrator.

Second, the language of section 502 supports this Court's result. It is true that section 502(d) explicitly permits suit against employee benefit plans. However, this Court does not read section 502(d) as a limitation on all section 502 actions. It is clear that section 502(c) allows suit against plan administrators and that section 502(a)(3) allows suit against fiduciary plan administrators. *See* 29 U.S.C. § 1132(c); *Curcio*, 33 F.3d at 234-35. The language of section 502(d) also infers that liability against a person may be established under section 502, as it provides that

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[6] Section 502(a)(3) provides that a civil action may be brought by a participant, beneficiary, or fiduciary:

> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
>
> (B) to obtain other appropriate equitable relief
>
> (i) to redress such violations or
>
> (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3).

judgments against a plan are not enforceable against any other person *"unless liability against such person is established in his individual capacity under this subchapter."* (emphasis added). Therefore, this Court finds that liability can be established against plan administrators under section 502(a)(1)(B).[6]

The question remains as to whether defendants are plan administrators. Defendants argue that the action must be dismissed because plaintiffs did not allege that they are plan administrators. Plaintiffs argue that they included allegations in each complaint which support a finding that the defendants were plan administrators, because they claimed that defendants operate health benefit systems which supplied health insurance policies which covered plaintiffs. (*See Edmonson* Complaint ¶¶ 6-7; *West* Complaint ¶¶ 4-5; *Collins* Complaint ¶¶ 4-5; *Bogurski* Complaint ¶¶ 4-5; *Levine* Complaint ¶¶ 6-7; *Bibbs* Complaint ¶¶ 6-8.)

Whether a defendant is a plan administrator is a factual question which requires an inquiry into the plan document and the factual circumstances surrounding the administration of the plan. *Hamilton*, 244 F.3d at 824. To succeed on a motion to dismiss, plaintiffs only need to

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[6] A plan "administrator" is defined as:

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

29 U.S.C. § 1002(16)(A).

show that the pleadings, when viewed in the light most favorable to them, allege facts which warrant relief. Here, the Court has considered plaintiffs' complaints and has found that they include allegations that support a finding that defendants are plan administrators. Therefore, it is plausible that defendants may be held liable under section 502(a)(1)(B) and defendants' argument that they are the "wrong" defendants does not warrant relief on this motion to dismiss.[7] This Court will therefore deny dismissal on this ground, but will require plaintiffs to file a clarifying amendment to their pleadings within fourteen days from the date of this decision which clarifies that they have brought suit against defendants in their status as plan administrators.

(c) Failure to exhaust administrative remedies

Defendants next argue that this Court should dismiss under section 502(a)(1)(B) because plaintiffs did not

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[7] The plan documents which have been submitted also support this conclusion as they indicate that defendants "maintained responsibility over the administration of the plan." *See Curcio*, 33 F.3d at 233.

On a motion to dismiss, the Court generally does not consider documents extraneous to the pleadings, but the Court may consider a "document integral or explicitly relied upon in the complaint . . . without converting the motion to dismiss into one for summary judgment." *In re Burlington Coat Factory Secs. Litig.*, 114 F.3d 1410, 1426 (3d Cir.1997). Here, the plaintiffs' claims are entirely based on the provisions within their employee benefit plans and defendants have expressly relied on the plan documents in filing the present motion. (*See* Defs.' Br. in *Levine* at 5-6 n. 2.) Thus, either party may cite to the benefit plan documents, since the plan is referred to in the complaints, without converting this Rule 12(b)(6) motion into a motion for summary judgment.

exhaust administrative remedies before filing this action. Plaintiffs argue that they should be excused from the exhaustion requirement because the facts of their cases show that bringing their claims in the administrative process would have been futile.

Every employee benefit plan must provide administrative remedies for participants whose claims for benefits have been denied. ERISA § 503; 29 U.S.C. § 1133. Because of this, the Third Circuit generally requires exhaustion of the administrative process under the plan before legal action may be instituted.[8] *D'Amico v. CBS Corp.*, 297 F.3d 287, 290-91 (3d Cir.2002). Exhaustion is intended to "reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned." *Harrow v. Prudential Ins. Co.*, 279 F.3d 244, 249 (3d Cir.2002) (quoting *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir.1980)). It also helps ERISA plan trustees to "expertly and efficiently manage their funds" because it "prevent[s] premature judicial intervention in their decision-making process." *Id.*

The Third Circuit strictly enforces the exhaustion requirement, but recognizes an exception to it "when resort to the administrative process would be futile."

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[8] The Third Circuit does not require exhaustion for section 502(a)(3) claims to enforce statutory rights established by ERISA, for section 510 discrimination claims, or for claims of failure to provide a summary plan description. *See Zipf v. AT & T*, 799 F.2d 889, 891 (3d Cir.1986); *Harrow v. Prudential Ins. Co.*, 279 F.3d 244, 253 (3d Cir.2002). A party cannot waive the exhaustion requirement by artfully pleading benefit claims as statutory rights claims. *Harrow*, 279 F.3d at 253.

Berger v. Edgewater Steel Co., 911 F.2d 911, 916 (3d Cir.1990). For the exception to apply, the plaintiff must provide a "clear and positive showing of futility" to the district court." *D'Amico*, 297 F.3d at 293. To determine whether to excuse exhaustion, the court should consider:

> (1) whether plaintiff diligently pursued administrative relief; (2) whether plaintiff acted reasonably in seeking immediate judicial review under the circumstances; (3) existence of a fixed policy denying benefits; (4) failure of the insurance company to comply with its own internal administrative procedures; and (5) testimony of plan administrators that any administrative appeal was futile.

Harrow, 279 F.3d at 250. If the court dismisses or grants summary judgment for failure to exhaust, it must do so without prejudice to plaintiff's refiling the claim after exhaustion of the administrative process. *D'Amico*, 297 F.3d at 294.

Here, plaintiffs readily admit that they never pursued their claims under their insurance policie administrative processes, but they argue that it would have been futile to do so. This Court has considered the five factors of the futility exception and has decided that it cannot determine whether the futility exception to the exhaustion requirement applies at this stage because the inquiry requires factual determinations. At this motion to dismiss stage, it does seem clear that plaintiffs did not "diligently pursue administrative relief" because they did not pursue administrative relief at all. However, it is unclear whether plaintiffs "acted reasonably in seeking judicial relief" or whether plaintiffs would have obtained relief in the administrative process. Prior to the New Jersey Supreme

Court's decision in *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001), each defendant insurer had a fixed policy denying benefits taken pursuant to the reimbursement and subrogation provisions. Factual issues remain as to whether the insurers still had a fixed policy denying benefits after *Perreira*. This Court will not make the factual determination at this time, though it has been presented with information on the subject. *See Bibbs*, Defs.' Br., Ex. A, Brill Decl. ¶ 4 (stating that "[a]s a direct result of the New Jersey Supreme Court's decision in *Perreira*, AmeriHealth stopped enforcing the reimbursement/subrogation provisions . . . and has no plans to do so in the future.)" *But see Bibbs*, Defs.' Br., Ex. B, Biemer Decl., Ex. 2 (requesting payment of lien on January 2, 2002, six months after *Perreira* was decided on June 26, 2001). At this time, it is enough that plaintiffs have shown a set of facts under which they may be granted relief by showing that exhaustion may have been futile. Therefore, this Court will not dismiss the present action for failure to exhaust. A defendant asserting that exhaustion would not be futile as a matter of fact in its individual circumstances may bring a motion for summary judgment on this ground.

For all of these reasons, this Court will deny defendants' motion to dismiss plaintiffs' claims under ERISA section 502(a)(1)(B). The Court will next consider whether the claims should be dismissed under ERISA section 514(a).

2. *Conflict Preemption Dismissal under Section 514(a)*

Defendants next argue that this Court should dismiss these actions because plaintiffs' state law claims are

conflict preempted by ERISA section 514(a). To determine whether the claims are conflict preempted, the Court must consider three clauses within section 514, namely the express preemption clause, the savings clause, and the deemer clause.

The express preemption clause, section 514(a), broadly preempts state regulations of employee benefit plans so that employee benefit plans are generally not subject to state regulation. It states:

> Except as provided in subsection (b) of this section [the savings clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .

29 U.S.C. § 1144(a). The savings clause, section 514(b)(2)(A), then "saves" state laws that govern insurance so that employee benefit plans may be subject to state laws that regulate insurance generally. It provides:

> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. § 1144(b)(2)(A). Then, the deemer clause, section 514(b)(2)(B), removes self-funded employee benefit plans from application of state laws that regulate insurance. It provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment

> company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B).[9]

The Supreme Court has noted that the "relationship between these clauses is not a model of legislative drafting." *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). However, the Court has instructed lower courts about the appropriate way to apply the sections to be consistent with Congressional intent. *Bill Gray Enter., Inc. v. Gourley*, 248 F.3d 206, 213 (3d Cir.2001). First, the court must determine if the state law relates to employee benefit plans to determine whether the law fits within section 514(a)'s express preemption clause. If the law relates to employee benefit plans, it is preempted unless the court determines that the state law regulates insurance so fits within section 514(b)(2)(A)'s savings clause. If it is a state insurance law, the court must then determine if the plan is a self-funded plan according to the deemer clause. If the plan is a self-funded plan, the state insurance law does not apply to the plan. If the plan is an insured plan, the state law applies.

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[9] The deemer clause prevents application of state insurance laws to self-funded employee benefit plans because it prevents the plans from being deemed insurance companies. *FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990). The clause does not prevent application of state insurance laws to insured employee benefit plans because the "insurance company that insures [the] plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause." *Id.*

Here, plaintiffs have brought unjust enrichment claims, arguing that the defendants violated New Jersey's collateral source statute, N.J.S.A. 2A:15-97, as interpreted by the Supreme Court in *Perreira v. Rediger*, 169 N.J. 399, 778 A.2d 429 (2001). Plaintiffs argue that the state anti-subrogation rule contained in the collateral source statute applies to their employee benefit plans. First, they argue that the statute does not "relate to" their employee benefit plans, so is not preempted. Second, they argue that if the statute relates to their plans, it still applies to their plans because it is a state insurance law saved by the savings clause. Third, they argue that the law applies under the deemer clause because defendants' plans are insured plans.

Defendants, on the other hand, argue that the antisubrogation rule does not apply to them because the statute is preempted because it relates to employee benefit plans and is not saved because it is not a state insurance law.

This Court has considered the arguments of counsel and has determined that the statute's anti-subrogation rule relates to employee benefit plans, is saved as a state law that regulates insurance, and applies to defendants' plans because they are insured plans. Therefore, for the following reasons, the New Jersey anti-subrogation rule is not preempted by ERISA and this Court must deny defendants' motion to dismiss based on ERISA's conflict preemption provision.

(a) Whether N.J.S.A. 2A:15-97 "relates to" plaintiffs' employee benefit plans

Plaintiffs argue that the New Jersey collateral source statute, N.J.S.A. 2A:15-97 does not relate to ERISA plans

because it is a law of general application that "does not in any way target ERISA plans." (Pls.' Br. at 6.) Defendants, however, argue that "[o]ne would be hard pressed to find a law that 'relates to' an employee benefit plan more than [this] state law that purports to invalidate terms of that plan." (Defs.' Reply in *Levine* at 12.)

A state law relates to an ERISA plan "if it has a connection with or reference to such a plan." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983)). The pre-emption provision is "clearly expansive," and yet should not be "taken to extend to the furthest stretch of its indeterminacy" where every state law would be pre-empted. *Egelhoff*, 532 U.S. at 146, 121 S.Ct. 1322 (quoting *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995)). The Supreme Court requires the district court to consider "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive as well as to the nature of the effect of the state law on ERISA plans" when deciding whether the law relates to an ERISA plan. *Egelhoff*, 532 U.S. at 147, 121 S.Ct. 1322 (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997)).

In 1990, the Supreme Court considered Pennsylvania's antisubrogation law and determined that it related to employee benefit plans even though it had general

applicability.[10] *Holliday*, 498 U.S. at 58, 111 S.Ct. 403. The Court explained that ERISA's preemption provision was not meant "to pre-empt only state laws specifically designed to affect employee benefit plans." *Id.* Instead, it was also intended to preempt certain laws of general application as its "pre-emptive scope [is] as broad as its language." *Id.* at 59, 111 S.Ct. 403 (quoting *Shaw*, 463 U.S. at 98, 103 S.Ct. 2890). The Court found that the Pennsylvania anti-subrogation law related to employee benefit plans because it:

> prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar anti-subrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide.*Id.* at 60, 103 S.Ct. 2890.

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[10] The Pennsylvania statute provided, in part:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . paid or payable under section 1719.

75 Pa. Cons.Stat. § 1720 (1987). Section 1719 provided that the anti-subrogation statute applied to:

> any program, group contract or other arrangement for payment of benefits . . . including, but not limited to, benefits payable by a hospital plan corporation or a professional health service corporation.

75 Pa. Cons.Stat. § 1719 (1987).

Plaintiffs argue that the New Jersey collateral source rule, interpreted by the New Jersey Supreme Court to include an antisubrogation rule, is different from the Pennsylvania antisubrogation law because the New Jersey law was initially passed as a "tort-reform effort aimed at eliminating double recoveries to plaintiffs and thereby controlling spiraling liability insurance costs." (Pls.' Br. at 5.) They argue that the collateral source statute, therefore, does not relate to employee benefit plans because it was not directly targeted toward employee benefit plans. (*Id.*)

This Court, however, finds that the New Jersey collateral source rule relates to employee benefit plans. While plaintiffs are correct that the statute itself does not mention subrogation, reimbursement, or health insurance plans, *see* N.J.S.A. 2A:15-97,[11] the New Jersey Supreme Court has determined that it was passed to affect employee benefit plans, *see Perreira v. Rediger*, 169 N.J. 399, 418, 778 A.2d 429 (2001). The court explained that when the statute was passed,

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[11] N.J.S.A. 2A:15-97 provides:

> In any civil action brought for personal injury or death, except actions brought pursuant to the provisions of [the No Fault Auto Insurance Law], if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds from a life insurance policy, shall be disclosed to the court and the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer directly by the plaintiff or by any member of the plaintiff's family on behalf of the plaintiff for the policy period during which the benefits are payable. Any party to the action shall be permitted to introduce evidence regarding any of the matters described in this act.

> [t]he Legislature had two choices: to benefit health insurers by allowing repayment of costs expended on a tort plaintiff, or to benefit liability carriers by reducing the tort judgment by the amount of health care benefits received. As the legislative history reveals, the choice was made to favor liability carriers. *Perreira*, 169 N.J. at 410-11, 778 A.2d 429. The court thus indicated that the Legislature was informed about the effect on health insurers; it made a choice to deny subrogation and reimbursement to health insurers. *Id.* at 411, 778 A.2d 429. The New Jersey Supreme Court found that the Legislature understood that its collateral source rule would require health insurers to accept the added risk that it would have to pay for injuries caused by third parties, so would lead them to calculate the "coverage and the premium for the insurance . . . on this unknown." *Id.* at 417, 778 A.2d 429.

Moreover, this Court sees no critical distinction between New Jersey's anti-subrogation law and Pennsylvania's antisubrogation law which was found by the United States Supreme Court to relate to employee benefit plans. The Pennsylvania statute does expressly prohibit subrogation and reimbursement, whereas the New Jersey statute has just been interpreted to contain the subrogation and reimbursement requirements. Each, though, has the same effect on employee benefit plans. No significant difference can result when one legislature includes the word "subrogation" in its statute and the other leaves the statute's effect on subrogation to the interpretation of the judiciary.

This Court thus finds that the New Jersey anti-subrogation rule, as contained in New Jersey's collateral source statute, relates to employee benefit plans.

(b) Whether N.J.S.A. 2A:15-97 is "saved" as a state law that regulates insurance

Having found that New Jersey's anti-subrogation rule relates to employee benefit plans, this Court must determine whether it is saved from preemption under ERISA section 514(b)(2)(A)'s savings clause. The Court finds that it is saved as a law that regulates insurance.

In deciding whether a law "regulates insurance" under ERISA's savings clause, the court must "start with a common-sense view of the matter under which a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Moran*, 122 S.Ct. at 2159 (quoting *Metropolitan Life Ins. Co.*, 471 U.S. at 740, 105 S.Ct. 2380; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987)). The court should focus on the "primary elements of an insurance contract[, which] are the spreading and underwriting of a policyholder's risk." *Moran*, 122 S.Ct. at 2159. The court should then "test the results of the common-sense enquiry" by considering the three factors used to determine what insurance laws are spared from federal preemption under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et seq.*[12] Laws regulating insurance for McCarran-Ferguson purposes are those which target practices that (1) have the "effect of transferring or spreading a policyholder's risk,"

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[12] The McCarran-Ferguson Act requires that the business of insurance be subject to state regulation, and, subject to few exceptions, provides requires that "[n]o Act of Congress shall be construed to invalidate . . . any law enacted by any State for the purpose of regulating the business of insurance . . . " *Moran*, 122 S.Ct. at 2159 n. 4 (quoting 15 U.S.C. § 1012(b)).

(2) are an "integral part of the policy relationship between the insurer and the insured," and (3) are "limited to entities within the insurance industry." *Moran*, 122 S.Ct. at 2163 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982)). The three factors are "guideposts;" a state law is not required to satisfy all three factors to be saved under the ERISA savings clause. *Id.*

Here, defendants argue that New Jersey's collateral source rule is not "saved" as a law regulating insurance because the common-sense inquiry shows that the law was not "specifically directed toward th[e insurance] industry." (Defs.' Br. in *Levine* at 26-27 (citing *Dedeaux*, 481 U.S. at 50, 107 S.Ct. 1549)). Defendants further argue that the three McCarran-Ferguson factors show that the collateral source rule is not an insurance law, arguing that the statute does not transfer the policyholder's risk to the insurer, is not an "integral part of the policy relationship between the insurer and the insured," and applies to all civil litigants, not just to "entities within the insurance industry." (Defs.' Br. in *Levine* at 29-32). Plaintiffs argue that there can be "no dispute" that the collateral source statute regulates insurance, mainly because the United States Supreme Court found that Pennsylvania's antisubrogation statute was an insurance regulation, *Holliday*, 498 U.S. at 60, 111 S.Ct. 403, and because the New Jersey Supreme Court explained that the New Jersey statute focuses on the insurance industry, *Perreira*, 169 N.J. at 409-412, 778 A.2d 429.

The common sense inquiry here does show that the collateral source rule was directed toward the insurance industry. Defendants are correct that the statute does not

refer to health insurance or to subrogation and reimbursement clauses, and that the statute states that it applies to plaintiffs in "any civil action" who receive benefits for their injuries from "any other source" besides the judgment. (Defs.' Reply in *Levine* at 14.) The Supreme Court of New Jersey recognized this as well, stating that "[o]n its face, N.J.S.A. 2A:15-97 . . . is silent regarding any right to subrogation or reimbursement on the part of the health insurers." *Perreira*, 169 N.J. at 409, 778 A.2d 429.

However, the court then aptly explained the history of the statute and its intended effect on insurance. It quoted the Passed Bill memo prepared by Governor's counsel which stated that:

> [t]*his bill attempts to reduce the cost of liability insurance* by reducing the likelihood of a "double recovery" in a liability award for items which were already compensated by insurance or by other "collateral" sources, other than a tortfeasor.

Perreira, 169 N.J. at 410, 778 A.2d 429 (emphasis in original). The New Jersey Supreme Court concluded that the statute had more than one purpose. "To be sure, its primary purpose was to disallow double recovery to plaintiffs, but a secondary goal was clearly the containment of spiraling insurance costs." *Id.* The court decided that the legislature made a "separate legislative decision" as to which "segment of the insurance industry" would be the beneficiary of the double recovery disallowance. *Id.* If health insurers were favored, they would be permitted to recover pursuant to subrogation and reimbursement liens and liability insurers would need to pay the full amount of a judgment; then, the insured would not double recover. *Id.* On the other hand, if liability insurers were favored, the health insurers would not be allowed to recover pursuant to

subrogation and reimbursement liens and the liability insurers would pay less than the full amount of a judgment by deducting amounts paid by the health insurer; then, the insured would not double recover. *Id.* The court found that the legislature decided to favor the liability insurance carriers by preventing the health insurance carriers from collecting pursuant to subrogation and reimbursement liens. *Id.* at 411-18, 778 A.2d 429.

The *Perreira* decision makes plain that the collateral source rule was directed toward insurance and has an intentional impact on the terms of insurance contracts. The court specifically held that in passing the statute, the legislature intended that health insurers be prevented from "invok [ing a] contract provision as a basis for reimbursement." *Id.* at 416, 778 A.2d 429. This Court will follow the *Perreira* court and also find that the statute was intended to directly effect and regulate the insurance industry.

The McCarran-Ferguson factors confirm this conclusion. First, the law has the effect of transferring or spreading a policyholder's risk. As explained by the Sixth Circuit, the "logical effect" of preventing the insurance companies from recovering paid medical costs from an insured's tort judgment is to "decrease the premiums of health care providers' insurance and increase the premiums of health insurance-i.e., spread risks." *Medical Mutual of Ohio v. deSoto*, 245 F.3d 561, 574 (6th Cir.2001). The New Jersey Supreme Court recognized that the New Jersey collateral source statute has this risk-shifting effect in the insurance industry, as it stated that one purpose of the collateral source statute is "to shift the burden, at least to some extent, from the liability and casualty insurance industry to health and disability third-party payers." *Perreira*, 169

N.J. at 411, 778 A.2d 429 (citing *Lusby v. Hitchner*, 273 N.J.Super. 578, 591, 642 A.2d 1055 (App.Div.1994)).

Second, the law is an integral part of the policy relationship between the insurer and the insured. The law requires plan providers to calculate benefit levels and premium amounts with the knowledge that they will be unable to recover monies expended for injuries caused to their insured by a third person. *Ward*, 526 U.S. at 374, 119 S.Ct. 1380. As a result, it "changes the bargain between insurer and insured." *Id.*

Defendants, however, argue that the statute is not an integral part of the insured's relationship with his insurer, but is a "matter of indifference" since its effect on the insured is:

> essentially non-existent. By definition, the insured plan participant received benefits for his medical care from the plan. The statute's only effect is to prohibit the participant from recovering the value of those benefits from the tortfeasor and transferring them back to the plan. At the end of the day . . . the participant remains in the same economic position in either event.

(Defs.' Br. in *Levine* at 31-32.) It is true that after a personal injury judgment, the plaintiff only recovers for his injuries once and likely does not care whether his health insurer or the tortfeasor's liability insurer bore the cost of his medical care. However, it is not true that the plaintiffs' overall economic position is the same. Because the antisubrogation rule places the responsibility for all medical payments on the health insurer, it also places responsibility

for higher premiums on the health insurer's insureds[13] As a result, this Court finds that the anti-subrogation rule is an integral part of the relationship between insurer and insured.

The third McCarran-Ferguson factor is also met here because the anti-subrogation rule is limited to entities within the insurance industry. Defendants argue that it is not limited to the insurance industry because the collateral source rule, on its face, refers to "all civil actions" and to amounts obtained from "any other source."

At issue here, though, is the anti-subrogation rule that is contained in the collateral source statute. It is a rule that the New Jersey Supreme Court has found targets the insurance industry and only applies to the insurance industry. The court summarized its holding by stating that a "health insurer, who expends funds on behalf of an insured, [cannot] recoup those payments through subrogation or contract reimbursement when the insured recovers a judgment against a tortfeasor." *Perreira*, 169 N.J. at 403, 778 A.2d 429. Such a rule is limited to entities within the insurance business.

For these reasons, this Court finds that the antisubrogation rule announced in *Perreira* and included in N.J.S.A. 2A:15-97 is saved from preemption under ERISA's savings clause as a state law which regulates insurance.

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[13] The insured under the health policy will likely not enjoy an equal reduction in his liability insurance premiums as there is no indication that everyone covered with health insurance is also covered by liability insurance.

(c) Whether N.J.S.A. 2A:15-97 applies in spite of the deemer clause

Because this Court has found that the anti-subrogation rule is saved by the savings clause, the rule applies to defendants unless the deemer clause exempts them from its application. The Supreme Court has made plain that the deemer clause only exempts self-funded employee benefit plans. Insurance companies are still subject to state insurance regulations even though they administer an employee benefit plan. *Holliday*, 498 U.S. at 61, 111 S.Ct. 403. Here, it is undisputed that defendants are insurance companies. As a result, they are not exempted from state insurance regulation through the deemer clause.

Therefore, this Court finds that the New Jersey antisubrogation rule relates to employee benefit plans, is saved from preemption as an insurance regulation, and applies to defendants in spite of the deemer clause. Therefore this Court will deny defendants' motion to dismiss because the state anti-subrogation provision is not conflict preempted.

C. *Additional Arguments for Motion to Dismiss*

Defendants have presented three additional alternative arguments to support their motion to dismiss. First, all defendants argue that the *Perreira* decision should not apply retroactively to the subrogation and reimbursement liens at issue in this case. Second, the defendants in *Levine*, *Bogurski*, and *Edmonson* argue that plaintiffs' claims should be dismissed under the voluntary payment doctrine. Third, the defendants in *Collins* and *West* argue that plaintiffs' claims should be dismissed for lack of

standing. This Court has considered the three arguments and will not dismiss based on them.

1. *Retrospective effect of Perreira v. Rediger, 169 N.J. 399 (2001)*

All of the consolidated defendants argue that plaintiffs' claims should be dismissed because *Perreira* was not intended to apply retrospectively to subrogation and reimbursement liens held before *Perreira*. This Court finds that *Perreira* may be applied retrospectively as it was in *Perreira*.

In New Jersey, a judicial decision generally applies retrospectively. *Reuter v. The Borough Council of The Borough of Fort Lee*, 167 N.J. 38, 42, 768 A.2d 769 (2001). Prospective application may be appropriate, though, if the decision establishes a new rule of law that is a "sudden and generally unanticipated repudiation of a long-standing practice." *Id.* (quoting *State v. Afanador*, 151 N.J. 41, 58, 697 A.2d 529 (1997)). Then, prospective application is only appropriate if (1) the parties and the community justifiably relied on the prior rule, (2) the purpose of the new rule will not be advanced by retroactive application, and (3) the retroactive application of the rule may have an adverse effect on the administration of justice. *Coons v. American Honda Motor Co.*, 96 N.J. 419, 426, 476 A.2d 763 (1984).

Defendants argue that *Perreira* announced a new rule of law that was a sudden and unanticipated change from the prior law of New Jersey. In support of their argument, they cite New Jersey Administrative Code section 11:4-42.10, a regulation promulgated by the Commissioner of Insurance eight years prior to *Perreira* that permitted

subrogation and reimbursement liens in insurance contracts.[14] *See Perreira*, 169 N.J. at 416, 778 A.2d 429 (quoting N.J.A.C. 11:4-42.10). Defendants argue that *Perreira* must be a new rule of law because now the law is the exact opposite of N.J.A.C. 11:4-42.10. (Defs.' Br. in *Levine* at 21-22.)

The problem with defendants' argument is that the New Jersey Supreme Court considered N.J.A.C. 11:4-42.10 and found that it was inconsistent with the existing law of New Jersey. *Perreira*, 169 N.J. at 416, 778 A.2d 429. The court determined that the long-standing law of New Jersey prevented subrogation and reimbursement liens. *Id.* at 418, 778 A.2d 429. Because the highest state court in New Jersey has determined that the collateral source statute always included the anti-subrogation rule, this Court will follow and find that *Perreira* reflected the existing law of New Jersey. As a result, in spite of N.J.A.C. 11:4-42.10, the decision in *Perreira* was not new and unanticipated.

Defendants have also failed to show the other three factors needed to justify prospective application of a decision. *First*, they argue that they relied on N.J.A.C. 11:4-42.10, but this reliance does not warrant relief because it was not reliance on prior state law. As explained *supra*, the New Jersey Supreme Court found that the regulation did not reflect the prior statutory law of the state. *Second*, defendants argue that the purpose of the *Perreira* rule will not be advanced by retroactive application because it will allow insureds to double recover. The

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[14] N.J.A.C. 11:4-42.10 was repealed after *Perreira* and a new rule was enacted in its place, effective August 5, 2002, which prohibits the inclusion of subrogation and reimbursement provisions in insurance contracts.

Court, however, has been presented with the allegations of plaintiffs that if the rule is not applied retroactively, they will not recover at all for their medical expenses.[15] Plaintiffs argue that the amount of medical expenses paid by defendants were never recovered in their settlement amounts pursuant to the collateral source rule's provision that any benefits for injuries received "from any other source . . . shall be deducted." N.J.S.A. 2A:15-97, *supra*. If they are forced to pay the health insurers now, for amounts which were deducted from the award, they will be paying such amounts out-of-pocket, and not out of a double-recovery. Retrospective application of the *Perreira* rule will avoid this result by letting them retain the settlement proceeds which do not contain amounts for medical expenses, and retain the health benefits previously paid by the health insurers. Retrospective application in such a situation would thus advance the purpose of the *Perreira* rule by avoiding the clear prospect that the insureds' medical expenses would be paid neither by their health plans nor by the third-party tortfeasors. *Third*,

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[15] It is clear that the plaintiffs' medical expenses were initially paid by the defendant health insurers. It is not clear that the third-party tort recoveries included amounts which paid for the same medical expenses. Plaintiffs' argue that

> defendants wrongly assume as fact that the underlying third-party recoveries included amounts in compensation for insured medical expenses. . . . Obviously, there can be no "double recovery" if a plaintiff never received money from the tortfeasor towards medical expenses in the first place. Thus, contrary to defendants' assertion that a refund of money to plaintiffs would cause them to recover twice, plaintiffs here could not even have been made whole since the defendants divested them of the recoveries they received for their uninsured losses.

(Pls.' Br. at 13.)

defendants have not shown that retroactive application of the rule will have an adverse effect on the administration of justice. They have argued that applying it retroactively would allow insureds to undo settlement agreements entered to satisfy the subrogation or reimbursement liens on their judgments. This argument raises an entirely different issue about the effect of a prior decision on a specific fact pattern. While a decision may have retrospective effect, it may not effect every prior cause of action. The Court will next address the arguments raised in the *Levine*, *Bogurski*, and *Edmonson* cases as to why the retrospective decision should not reach plaintiffs' claims in their particular cases. As for general retrospectivity, though, defendants have failed to show an adverse effect on the administration of justice. Applying *Perreira* retrospectively should aid justice by ensuring that plaintiffs recover, but do not double recover.

For these reasons, this Court finds that *Perreira* applies retrospectively and will not dismiss based on this argument.

2. *Voluntary payment doctrine as applied to Levine, Bogurski, and Edmonson claims*

The defendants in the *Levine*, *Bogurski*, and *Edmonson* actions argue that the *Perreira* decision does not allow plaintiffs to recover monies that they voluntarily agreed to pay defendants to satisfy the liens on their settlement awards. In each case, defendants sent plaintiffs a collection letter and, in response, plaintiffs agreed to pay a lesser amount in full satisfaction of the lien. Defendants argue that the voluntary payment doctrine prevents plaintiffs from "undoing" these settlement agreements.

Under New Jersey law, if a party pays a tax or a fee that is later "set aside by judicial decision," there is a presumption that the taxing entity should refund the money because it "can no longer be honestly retained." *In re: N.J. State Board of Dentistry*, 84 N.J. 582, 587, 423 A.2d 640 (1980). Otherwise, the taxing entity would enrich itself unjustly at the expense of the party, which would "violate one of the cardinal principles of the common law, requiring restitution to prevent unjust enrichment." *Id.* The main exception to this rule is the voluntary payment doctrine. It provides that "where a party, without mistake of fact, or fraud, duress or extortion, voluntarily pays money on a demand which is not enforceable against him, he cannot recover it back." *Id.* at 588, 423 A.2d 640. If the party mistakenly believed that he was legally required to make the payment, his mistake of law will not allow him to recover the money because the rule is premised on the theory that:

> [e]very man is supposed to know the law, and if he voluntarily makes a payment which the law would not compel him to make, he cannot afterwards assign his ignorance of the law as a reason why the state should furnish him with legal remedies to recover it back.

Id.

The voluntary payment doctrine, thus, only prevents restitution of amounts previously paid if (1) the payment was voluntarily made, (2) the payor was not under any mistake of fact, and (3) the circumstances of the payment were proper. All are factual questions. 66 Am.Jur.2d § 108.

Defendants argue that the voluntary payment doctrine applies to the claims of plaintiffs Levine, Bogurski,

and Edmonson because they voluntarily paid sums in satisfaction of the subrogation and reimbursement liens. While plaintiffs may have been acting under a mistake of law because they thought the liens were enforceable, defendants argue that their mistake of law does not provide relief from the voluntary payment doctrine. (Defs.' Br. in *Levine* at 19.) Plaintiffs argue that their claims should not be dismissed under the voluntary payment doctrine on a motion to dismiss because determining whether it applies "raise[s] a multitude of factual issues." (Pls.' Br. at 11.)

Plaintiffs are correct that this Court cannot dismiss at this juncture based on the voluntary payment doctrine because facts exist under which plaintiffs could be relieved from its application. First, plaintiffs' payment may not have been voluntary because a payment is not voluntary when the plaintiff believed that the law which imposed it was not valid, but made the payment anyway.[16] *N.J. State Bar Ass'n v. Berman*, 259 N.J.Super. 137, 155, 611 A.2d 1119 (App.Div.1992). Such situations generally arise when a plaintiff pays a fee that he believes is invalid, but pays it anyway so that he can continue to practice his profession or continue his business. *See State Board of Dentistry*, 84 N.J. at 588-89, 423 A.2d 640. This Court cannot decide on a motion to dismiss whether plaintiffs believed that the

[16] A payment is voluntary when made by a plaintiff who believes that the law imposing it is valid, even if the law is later invalidated. *Continental Trailways v. Director, Div. of Motor Vehicles*, 102 N.J. 526, 549-50, 509 A.2d 769 (1986).

subrogation and reimbursement liens were invalid, but paid in order to continue their health insurance coverage.[17]

Second, the Court cannot now determine whether plaintiffs acted under a mistake of fact when they made the payments or whether defendants acted improperly in making their claims. Plaintiffs state that defendants demanded reimbursement from their settlements or judgments and claimed that they were only seeking the amount of the award that compensated for medical expenses even though plaintiffs "never received money from the tortfeasor towards medical expenses in the first place." (Pls.' Br. at 13.) The Court will not now determine whether plaintiffs made the payments under a mistake of fact, believing that they were paying amounts compensated in their awards, or whether defendants misled plaintiffs into such a belief. Such are questions of fact that are not appropriate at this stage.

Therefore, this Court will not dismiss the claims of plaintiffs Levine, Bogurski, and Edmonson for this reason. This decision is without prejudice to a defendant's right to address this issue on summary judgment when factual development has occurred.

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[17] Defendants present exhibits to support this argument. (*See* Defs.' Br. in *Edmonson*, Exs. A, B; Defs.' Br. in *Bogurski*, Exs. B, C, D; Defs.' Br. in *Levine*, Exs. 2, 3.) The Court cannot make factual determinations based on the documents on this motion to dismiss because plaintiffs claims are not "based on the document[s]." *Pension Benefit Guar. Corp. v. White Consol. Indus., Inc.*, 998 F.2d 1192, 1196 (3d Cir.1993). Regardless, the letters only show amounts were claimed and paid; they do not show whether such payments were voluntary.

3. *Standing doctrine as applied to Collins and West claims*

The defendants in the *Collins* and *West* actions argue that this Court should dismiss for lack of standing under the Constitution because plaintiffs Collins and West have not suffered an injury in fact since defendants' records show that they never paid anything to satisfy the subrogation and reimbursement liens.[18]

It is clear that plaintiffs have statutory standing to sue for benefits under ERISA section 502(a)'s civil enforcement provision because they have each alleged that they are plan participants of the employee benefit plans from which they seek benefits. *See* 29 U.S.C. § 1132(a) (allowing civil action "by a participant or beneficiary to recover benefits due to him under the terms of his plan"). Status as a plan participant which provides statutory standing under ERISA section 502(a), however, does not necessarily provide constitutional standing. *Olsen v. Hegarty*, 180 F.Supp.2d 552, 564 (D.N.J.2001). A plaintiff must also establish constitutional standing by showing (1) that he suffered an injury-in-fact, (2) that the injury was caused by the named defendant or at least "fairly traceable to the challenged action of the defendant," and (3)

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[18] Defendants in the *Collins* and *West* matters argue that Counts I through III in the plaintiffs' complaints in their cases should be dismissed for this additional reason. They also argue that the motion should be granted as unopposed because plaintiffs did not specifically reply to this additional standing argument. However, the Court will not grant the motion as unopposed. All parties were encouraged to avoid repetitive briefing and the plaintiffs answered the standing argument in response to the *Bibbs* defendant's summary judgment motion, addressed in section II(D), *infra*. The Court will consider plaintiffs' arguments in *Bibbs* for this *Collins*, and *West* motion.

that a favorable decision by the court would likely redress his injury.[19] *Pryor v. Nat'l Collegiate Athletic Ass'n*, 288 F.3d 548, 561 (3d Cir.2002) (quoting *Bennett v. Spear*, 520 U.S. 154, 167, 117 S.Ct. 1154, 137 L.Ed.2d 281 (1997)). The sole issue here is whether plaintiffs Collins, West, and Bibbs have alleged an "injury in fact" when defendants claim they have not paid any monies in satisfaction of the subrogation and reimbursement liens on their settlements.

An injury in fact is an "invasion of a legally protected interest which is (a) concrete and particularized; and (b) actual or imminent, not conjectural or hypothetical." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992). An injury in fact may "exist solely by virtue of a statute that creates legal rights, the invasion of which creates standing." *Warth v. Seldin*, 422 U.S. 490, 500, 95 S.Ct. 2197, 45 L.Ed.2d 343 (1975).

Here, Congress passed ERISA to "protect the interests of participants in employee benefit plans . . . by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). In the present suit, plaintiffs seek to protect their rights in their employee benefit plans in federal court; they have alleged that defendants "asserted subrogation liens" against them which unlawfully denied them benefits under their plans. (*Collins* Complaint ¶ 15; *West* Complaint ¶ 15.) Moreover, while defendants argue that plaintiffs have not made payment pursuant to the liens, the *Collins* and *West* complaints, upon which this Court must rely and accept as

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[19] When standing is challenged on the basis of the pleadings, the court must "accept as true all material allegations of the complaint, and . . . construe the complaint in favor of the complaining party." *Pennell v. City of San Jose*, 485 U.S. 1, 7, 108 S.Ct. 849, 99 L.Ed.2d 1 (1988).

true, state that "Defendant required Plaintiff . . . to reimburse Defendant for those funds expended on behalf of Plaintiff." (*Collins* Complaint ¶ 15; *West* Complaint ¶ 15.)

This Court therefore finds that plaintiffs have alleged an injury in fact in their complaints which is sufficient to support constitutional standing.[20] The Court will not dismiss the *Collins* and *West* complaints for this reason. If, however, the defendants in *Collins* and *West* were to withdraw their lien claims, with no reimbursement payments having been made by plaintiffs, one would be hard pressed to find an invasion of a legally protected interest under *Lujan*, or that a favorable decision of the Court would redress such injury where the defendant has already remedied the situation.[21]

D. *Bibbs v. AmeriHealth, Inc., Civ. No. 02-1155(JBS) Summary Judgment Motion*

Defendant AmeriHealth seeks summary judgment on plaintiff Bibbs' claims for compensatory damages because plaintiff never paid the subrogation lien on his settlement. Defendant also seeks summary judgment on Bibbs' claims for prospective relief under the mootness doctrine because defendant has irrevocably released the subrogation lien.

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[20] Defendants have not contested the two other requirements for constitutional standing. Both are present here. Causation is clear as plaintiffs repeatedly allege in their complaints that defendants asserted the unlawful subrogation and reimbursement liens. Redressability is also present because the Court may provide relief that will "ensure that the Plan is protected in the future" and that the plaintiffs are "compensated for the past." *See Olsen*, 180 F.Supp.2d at 565.

[21] Defendant AmeriHealth has done precisely this with respect to plaintiff Bibbs' claim, as discussed in section II(D), *infra*.

Plaintiff argues the merits of these claims, but also infers that the present motion for summary judgment is improper, stating that:

> AmeriHealth has not responded to any of plaintiff's outstanding discovery requests, or even provided a Rule 26 Disclosure Statement. Despite this, defendant has nonetheless moved for summary judgment on what it incorrectly describes as the "undisputed facts."

(Pl.'s Br. in *Bibbs* at 2.)

Under Fed.R.Civ.P. 56, a defendant may move "at any time" for summary judgment. If necessary, a plaintiff may seek additional time for discovery required to fairly address the motion. Fed.R.Civ.P. 56(f). To do so, the plaintiff must file an affidavit that identifies "with specificity what particular information is sought; how, if uncovered, it would preclude summary judgment; and why it has not previously been obtained." *Bradley v. United States*, 299 F.3d 197, 206 (3d Cir.2002). The Third Circuit strictly observes this procedural requirement.[22] *Id.* at 207.

Plaintiff has not filed an affidavit here, has not asked for additional time for discovery, and has not indicated what further discovery is needed to support its argument. It would appear that plaintiff himself would be in possession of any relevant information tending to show he has suffered, or likely will suffer, some cognizable injury.

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[22] The Third Circuit has a presumption against allowing constructive compliance with the Rule 56(f) affidavit requirement. *Bradley*, 299 F.3d at 207. Failure to comply with Rule 56(f) is fatal to a claim of insufficient discovery "in all but the most exceptional cases." *Id.* This is not the exceptional case.

Instead, plaintiff has argued the merits of this motion and has presented the Court with his own supporting evidence. Therefore, this Court will consider this motion for summary judgment.

1. *Compensatory Relief Claims*

Defendant AmeriHealth argues that this Court should grant summary judgment[23] on plaintiff Bibbs' claims for compensatory relief because plaintiff does not have standing since he never paid the subrogation lien that AmeriHealth asserted. (Defs.' Br. at 2; Statement of Fact ¶ 3.) Plaintiff admits that he never paid the subrogation lien,

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[23] Summary judgment is appropriate when the record shows that "there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). A dispute is "genuine" if "the evidence is such that a reasonable jury could return a verdict for the non-moving party." *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). A fact is "material" only if it might affect the outcome of the suit under the applicable rule of law. *Id.* In deciding whether there is a disputed issue of material fact, the court must view the evidence in favor of the non-moving party by extending any reasonable favorable inference to that party. *Hunt v. Cromartie*, 526 U.S. 541, 552, 119 S.Ct. 1545, 143 L.Ed.2d 731 (1999).

The moving party always bears the initial burden of showing no genuine issue of material fact exists, regardless of which party ultimately would have the burden of persuasion at trial. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). However, where the nonmoving party bears the burden of persuasion at trial, "the burden on the moving party may be discharged by 'showing'-that is, pointing out to the district court-that there is an absence of evidence to support the nonmoving party's case." *Id.* at 325, 106 S.Ct. 2548. The non-moving party "may not rest upon the mere allegations or denials of" its pleading to show a genuine issue exists and must do more than rely only "upon bare assertions, conclusory allegations or suspicions." Fed.R.Civ.P. 56(e); *Gans v. Mundy*, 762 F.2d 338, 341 (3d Cir.1985).

but argues that summary judgment should not be granted because AmeriHealth tried to collect the lien after the *Perreira* case made clear that the lien was unlawful. (Pl.'s Br. at 3-4.)

As the Court explained *supra* in section II(C)(3), a plaintiff must establish constitutional standing by showing (1) that he suffered an injury-in-fact, (2) that the injury was caused by the named defendant, and (3) that a favorable decision by the court would likely redress his injury. *Pryor*, 288 F.3d at 561. This Court finds that summary judgment must be granted in favor of defendant because there is no question of fact that plaintiff did not suffer the injury he alleges or that this Court cannot provide the relief he seeks to redress the injury.

First, plaintiff alleges that the suffered injury is the "millions of dollars which defendants collected" through the assertion of unlawful subrogation liens. (Complaint ¶ 5.) There is no question of fact, though, that defendants did not collect any money from plaintiff Bibbs pursuant to a subrogation lien. (Statement of Facts ¶ 3.) While he may have suffered some inconvenience when he received collection letters from AmeriHealth, he has not presented any evidence that indicates that he in any way paid AmeriHealth or incurred any other expense because of lien. This absence of evidence leads the Court to conclude that plaintiff did not suffer the injury he asserts.

Second, plaintiff seeks redress for the amounts taken pursuant to "unlawful subrogation liens." He describes his action as one brought "to recover money obtained from accident victims by their health carriers, through defendants' assertion of these unlawful so-called health care subrogation liens." (Complaint ¶ 2.) This Court cannot

provide redress for amounts taken pursuant to the subrogation lien when it is clear that nothing was taken from Bibbs pursuant to the lien.

Plaintiff also does not have standing to support his claims by asserting claims of others who have had amounts taken pursuant to subrogation liens. Third Circuit law is clear that named plaintiffs must show that they personally have been injured. *Klein v. Gen'l Nutrition Cos.*, 186 F.3d 338, 345 (3d Cir.1999) (citing *Lewis v. Casey*, 518 U.S. 343, 357, 116 S.Ct. 2174, 135 L.Ed.2d 606 (1996)). It is not enough to show that other members of a class that they purport to represent have suffered an injury. *Id.; accord Holmes v. Pension Plan of Bethlehem Steel Corp.*, 213 F.3d 124, 135 (3d Cir.2000).

Therefore, this Court will grant defendant's motion for summary judgment on plaintiff Bibbs' compensatory claims because there is no question of fact that plaintiff does not have standing to pursue such claims.

2. *Prospective Relief Claims*

Defendant AmeriHealth argues that this Court should grant summary judgment on plaintiff Bibbs' claims for prospective relief because they are moot. Defendant argues that there is no longer any controversy because it has revoked the subrogation lien that it placed on plaintiff Bibbs' settlement before the *Perreira* decision. (Defs.' Br. at 3.) Plaintiff argues that defendant's voluntary decision to release the subrogation lien does not render the case moot. (Pl.'s Br. at 4.)

The district court only has authority to consider actual, ongoing "cases and controversies." *Khodara Env'l,*

Inc. v. Beckman, 237 F.3d 186, 192-93 (3d Cir.2001) (quoting U.S. Const. art II, § 2, cl. 1). If "developments occur during the course of adjudication that eliminate a plaintiff's personal stake in the outcome or prevent a court from being able to grant the requested relief, the case must be dismissed as moot." *County of Morris v. Nationalist Movement*, 273 F.3d 527, 533 (3d Cir.2001). However, as a general rule, voluntary cessation of challenged conduct during the course of the adjudication does not make the case moot unless "(1) it can be said with assurance that there is no reasonable expectation that the alleged violation will recur, and (2) interim relief or events have completely and irrevocably eradicated the effects of the alleged violation." *Phillips v. Pa. Higher Educ. Assis. Agency*, 657 F.2d 554, 569 (3d Cir.1981) (quoting *County of Los Angeles v. Davis*, 440 U.S. 625, 631, 99 S.Ct. 1379, 59 L.Ed.2d 642 (1979)). Then, "it may be said that the case is moot because neither party has a legally cognizable interest in the final determination of the underlying questions of fact and law." *Id.* The burden of demonstrating mootness "is a heavy one." *Id.*

Defendant AmeriHealth has submitted clear evidence that it has voluntarily ceased the challenged conduct. In a letter dated April 25, 2002 defendant informed plaintiff's counsel that:

> As we previously discussed,[AmeriHealth] initially asserted a subrogation lien against William Bibbs based on the belief that the injuries for which benefits were paid arose out of a worker's compensation claim. Although we still have not received definitive information regarding Mr. Bibbs' knee injury and AmeriHealth has every right to assert a subrogation lien if the benefits were recovered as part of a workers' compensation claim, my client as we

> have informed you in the past, has revoked its lien against Mr. Bibbs.
>
> In order to ensure that there is no misunderstanding, AmeriHealth ***is not*** asserting a lien, or any other interest or legal right or claim, against Mr. Bibbs.

(Biemer Cert., Ex. 1 at 1) (emphasis in original). Then, in a letter dated April 30, 2002, defendant clarified its position, stating:

> Please be advised that my letter to you dated April 25, 2002 will serve as final notice that AmeriHealth, Inc. is not pursuing a lien against William Bibbs. Because Mr. Bibbs is represented by counsel, AmeriHealth will not directly notify Mr. Bibbs or follow up with his counsel in the underlying matter.

(Biemer Cert., Ex. 1 at 2.) Defendants also present the certification of Martin Brill, Vice President-Finance of AmeriHealth HMO, Inc., who states that "[a]s a direct result of the New Jersey Supreme Court's decision in *Perreira*, AmeriHealth stopped enforcing the reimbursement/subrogation provisions contained in its health insurance contracts . . . and has no plans to do so in the future." (Brill Cert. ¶ 4.) Mr. Brill also certifies that "[g]iven the *Perreira* decision, AmeriHealth has decided not to pursue the lien, or for that matter any other interest or legal right or claim against Plaintiff." (*Id.* ¶ 5.)

While voluntary cessation of challenged conduct during the litigation may not always make a case moot, the present case is moot based on the two factors elucidated by the Supreme Court. First, there is no reasonable expectation here that the violation will recur. New Jersey

law is now clear that insurance companies cannot enforce reimbursement and subrogation liens and cannot include reimbursement and subrogation provisions in their insurance policies. New Jersey Administrative Code section 11:4-42.10 provides:

> (a) No policy or certificate providing group health insurance shall limit or exclude health benefits as the result of the covered person's sustaining a loss attributable to the actions of a third party.
>
> (b) Insurers shall file with the Commissioner no later than December 31, 2002, endorsements that remove any subrogation and third party recovery provisions contained in previously filed contract, policy or certificate forms.

Bulletin No. 01-11 of the Department of Insurance states:

> Health carriers are . . . directed immediately to cease all subrogation and recovery efforts against persons covered by group or individual contracts or policies issued in New Jersey . . . regardless of whether these contracts include subrogation or reimbursement provisions.

Given the clarity of New Jersey law on this issue after *Perreira*, it is reasonable to assume that defendant AmeriHealth will not seek to enforce its lien against plaintiff Bibbs.[24]

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[24] Plaintiff has presented a letter dated January 2, 2002 in which defendant asserted its subrogation lien and stated that the amount of the lien "may increase." (Pl.'s Br., Ex. A.) Plaintiff argues that because this letter was sent after the July 5, 2001 Department of Insurance Bulletin had directed all recovery efforts to stop, defendants are likely to continue their recovery efforts in spite of the law of the state. (Pl.'s

(Continued on following page)

Second, interim events have eradicated the effects of the alleged violation here. While a subrogation lien was placed on plaintiff Bibbs' recovery, he never paid anything to satisfy the lien. (Brill Cert. ¶ 5.) Defendants have unequivocally released the lien against his settlement proceeds. (Biemer Cert., Ex. 1.) Plaintiff Bibbs has changed health insurance carriers and is no longer covered by defendant AmeriHealth. (Brill Cert. ¶ 5.) These events during the pendency of this litigation have cured the effects of the subrogation lien asserted against plaintiff.

For these reasons, this Court will dismiss plaintiff Bibbs' claims for prospective relief as moot, and judgment will be entered in favor of defendant AmeriHealth.

III. *CONCLUSION*

For the reasons stated herein, the motions to dismiss of defendants Horizon Blue Cross Blue Shield of New Jersey, Oxford Health Plans, Inc., AmeriHealth, Inc., Health Net of the Northeast, Inc., and United Healthcare Corporation, [Docket Items 40-1, 42-1, 48-1, 50-1, 50-2, and 54-1] will be denied. Defendant CIGNA's conditional motion to dismiss, [Docket Item 52-1], will be dismissed as moot. Defendant AmeriHealth, Inc.'s motion for summary judgment on plaintiff Bibbs' claims, [Docket Item 48-2], will be granted. Plaintiffs in *Levine*, *West*, *Collins*, *Bogurski*, and *Edmonson* shall file an amendment to their Complaints to clarify that defendants are sued in their capacities as plan administrators within fourteen days.

Br. at 4-5.) This Court will still assume that defendant AmeriHealth will abide by its intention to assert no such lien in the future.

The accompanying Order is entered.

ORDER

This matter having come before the Court on the consolidated defendants' motions to dismiss, [Docket Items 40-1, 42-1, 48-1, 50-1, 50-2, 52-1, 54-1], and on defendant AmeriHealth, Inc.'s motion for summary judgment on plaintiff Bibbs' claims, [Docket Item 48-2]; and this Court having reviewed the submissions on these matters by all parties; and for the reasons in the Opinion issued this date;

IT IS this 4th day of March, 2003, hereby

ORDERED that defendant CIGNA HealthCare of New Jersey, Inc.'s conditional motion to dismiss plaintiff Dellece L. Barbour's complaint [Docket Item 52-1] be, and hereby is, ***DISMISSED AS MOOT***;

IT IS FURTHER ORDERED that the motions to dismiss of defendants Horizon Blue Cross Blue Shield of New Jersey, AmeriHealth, Inc., Oxford Health Plans, Inc., Health Net of the Northeast, Inc., and United Healthcare Corporation, for failure to state a claim on which relief may be granted [Docket Items 40-1, 42-1, 48-1, 50-1, 50-2, and 54-1] be, and hereby are, ***DENIED***; and

IT IS FURTHER ORDERED that plaintiffs have fourteen (14) days from the date of this decision to file a clarifying amendment to their Complaints which clarifies that they have brought suit against defendants in their status as plan administrators; and

IT IS FURTHER ORDERED that Defendant AmeriHealth, Inc.'s motion for summary judgment on Plaintiff

Bibbs' Complaint [Docket Item 48-2] be, and hereby is, ***GRANTED***; and

IT IS FURTHER ORDERED that summary judgment for defendant AmeriHealth and against plaintiff Bibbs be entered in Civil No. 02-1155(JBS).

2002 WL 31262100 (D.N.J.)

United States District Court, D. New Jersey.
Caroline CARDUCCI, et al., Plaintiffs,
v.
AETNA U.S. HEALTHCARE, Defendant.
Jean LEVINE, Plaintiff,
v.
UNITED HEALTHCARE CORP., Defendant.
Carole WEST, Plaintiff,
v.
HEALTH NET OF THE NORTHEAST, Defendant.
David COLLINS, Plaintiff,
v.
OXFORD HEALTH PLANS, Defendant.
Noreen BOGURSKI, Plaintiff,
v.
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, Defendant.
Benjamin EDMONSON, Plaintiff,
v.
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, Defendant.
Dellece L. BARBOUR, Plaintiff,
v.
CIGNA CORPORATION, d/b/a Cigna Healthcare Corporation, Defendant.
Nos. Civ.A.01-4675(JBS), Civ.A.01-4964(JBS), Civ.A.01-5217(FCL), Civ.A.01-5237(JWB), Civ.A.01-5339(AMW), Civ.A.01-5812(JBS), Civ.A.02-417(JBS).

July 24, 2002.

Natalie A. Finkelman, Scott R. Shepherd, James C. Shah, Shepherd & Finkelman, LLC, Washington Professional Campus, Turnersville, NJ, and John W. Trimble, Jr., Morrison & Trimble, Washington Professional Campus,

Turnersville, NJ, for plaintiffs Carducci, Levine, and Edmonson.

Franklin P. Solomon, Weitz & Luxenberg, Cherry Hill, NJ, and Donna Siegel Moffa, Lisa J. Rodriguez, Trujillo, Rodriguez & Richards, LLC, Haddonfield, NJ, for plaintiffs West, Collins, and Bogurski.

Burt M. Rublin, Raymond A. Quaglia, Ballard Spahr Andrews & Ingersoll, LLP, Philadelphia, PA, for defendant Aetna U.S. Healthcare, Horizon Blue Cross Blue Shield of NJ, Horizon Healthcare Services.

Edward S. Wardell, Kelley, Wardell & Craig, LLP, Haddonfield, NJ, for defendant Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey, and also for defendant Aetna U.S. Healthcare, Horizon Blue Cross Blue Shield of NJ, Horizon Healthcare Services.

William J. O'Shaughnessy, Harvey C. Kaish, B. John Pendleton, McCarter & English, LLP, Newark, NJ, for defendants Oxford Health Plans, Inc. and Health Net of the Northeast, Inc.

Theodore D. Aden, Carol A. Lafond, Leboeuf, Lamb, Greene & McRae, LLP, Newark, NJ, and Edward A. Scallet, Thomas F. Fitzgerald, William F. Hanrahan, Groom Law Group, Chartered, Washington, DC, for defendant United Healthcare Corp., k/n/a United Health Group, Inc.

MEMORANDUM OPINION

SIMANDLE, J.

1. *INTRODUCTION*

This action is before this Court in these consolidated cases[1] on plaintiffs' motion to alter or amend this Court's May 28, 2002 Opinion and Order denying remand (*see Carducci v. Aetna U.S. Healthcare*, 204 F.Supp.2d 796 (D.N.J.2002)), and also to stay further proceedings in this action. Plaintiffs essentially seek the addition of language that would allow them to seek an interlocutory appeal of this Court's denial of their remand motion pursuant to 28 U.S.C. § 1292(b). This Court will therefore treat the motion as seeking certification of an interlocutory appeal to the United States Court of Appeals for the Third Circuit under 28 U.S.C. § 1292(b). Defendants oppose this motion, arguing that no certification should occur because plaintiffs have failed to show that there is a "substantial ground for difference of opinion" as to this Court's correctness or that a grant of interlocutory appeal would materially advance the ultimate termination of the litigation. For the reasons stated herein, plaintiffs' motion for certification of the remand question resolved in this Court's May 28, 2002 Opinion and Order will be denied without prejudice.

2. *ANALYSIS*

Section 1292(b) reads, in part:

> When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order

[1] The first six above-captioned cases were consolidated prior to the May 28, 2002 Opinion and Order at issue here. The seventh case – *Barbour v. Cigna Corp., d/b/a Cigna Healthcare Corp.*, Civil No. 02-00417(JBS) – was consolidated by Consent Order filed June 28, 2002.

> involves a controlling question of law as to which there is a substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he shall so state in writing in such order. . . .

28 U.S.C. § 1292(b).[2] It is within the district court's discretion whether or not to certify for appeal a controlling question of law. Additionally, a Section 1292(b) is limited to cases where "exceptional circumstances" justify the general policy of postponing appellate review until entry of a final order. *See Coopers & Lybrand v. Livesay,* 437 U.S. 463, 468, 98 S.Ct. 2454, 2457 (1978); *In re Ford Motor Co. Ignition Switch Products Liability Litigation,* 1999 U.S. Dist. LEXIS 22891, *14 (D.N.J. Jul. 27, 1999) (quoting *Hulmes v. Honda Motor Co., Ltd.,* 936 F. Supp 195, 208 (D.N.J.1996), *aff'd,* 141 F.3d 1154 (3d Cir.1998)).

There are three components a district court must consider when deciding whether to grant certification under 28 U.S.C. § 1292(b). First, the court must consider whether the order at issue involves a controlling issue of law. A controlling issue of law is one that, if erroneously decided, would result in reversible error on final appeal. *Katz v. Carte Blanche Corp.,* 496 F.2d 747, 755 (3d Cir.) (en banc), *cert. denied,* 419 U.S. 885 (1984). Second, there must be a substantial ground for difference of opinion concerning the resolution of the question to be presented for Section 1292(b) appeal. *Katz,* 496 F.2d at 754. That an

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[2] As indicated by the remaining language of Section 1292(b), an appeal under that section also requires the Court of Appeals to accept any certification of a controlling question of law before an interlocutory appeal under that section may be heard.

issue is one of first impression in a circuit or that other circuits disagree is not necessarily sufficient to fulfill this requirement. Third, an immediate appeal must materially advance the ultimate termination of litigation. *Katz,* 496 F.2d at 754. The movant bears the burden of showing that these three components are met. *Waldorf v. Borough of Kenilworth,* 959 F.Supp. 675, 679 (D.N.J.1997); *Kapossy v. McGraw-Hill, Inc.,* 942 F.Supp. 996, 1004 (D.N.J.1996).

1. *Controlling Question of Law*

This Court denied plaintiff's motion to remand this action to state court, finding that plaintiff's claims were within this federal court's jurisdiction under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), because, in the statute's words, plaintiffs seek "to recover benefits due to [them] under the terms of [their] plan." Plaintiffs' motion for § 1292(b) certification does not define the precise controlling issue of law to be presented upon interlocutory review. There can be little doubt, however, that the question for interlocutory review could be framed as follows: "Whether the District Court correctly determined that plaintiff's unjust enrichment claims against their healthcare insurers, which had collected these monies from plaintiffs' tort recoveries pursuant to the subrogation provisions of plaintiffs' ERISA plans, are claims for recovery of benefits due under those plans, within the meaning of Section 502(a)(1)(B) of ERISA." If this Court erroneously decided that issue, then it would result in reversal on final appeal, because this court would have been without jurisdiction over the action. Defendants do not contend that the issue decided in this Court's May 28, 2002 Opinion and Order is not a controlling question of law – they concede for the purpose of this motion that it is.

(*See* Defs.' Br. in Opp. to Pls.' Mot. at 3, n.3.) This Court agrees.

2. *Substantial Ground For Difference of Opinion*

In their moving statement in lieu of a brief, plaintiffs assert that the extensive oral argument heard by this Court along with the lengthy Opinion considering remand support their position that there is substantial ground for difference of opinion on the remand issue. Defendants argue that plaintiffs have fallen short of meeting their burden of showing that a substantial ground for difference of opinion exists.

The Court agrees that plaintiffs have failed to meet their burden of presenting anything other than disagreement with the Court's ruling, which does not constitute a substantial ground for difference of opinion under Section 1292(b). *P. Schoenfeld Asset Mgmt., LLC v. Cendant Corp.*, 161 F.Supp.2d 355, 360 (D.N.J.2001); *Kapossy v. McGraw-Hill, Inc., supra*, 942 F.Supp. at 1001. As discussed at length in this Court's May 28, 2002 Opinion, which considered all of the remand briefs and argument previously submitted, plaintiffs have not offered any explanation of what the monies plaintiffs received were if they were not benefits under an ERISA plan. Their civil actions seek recovery of plan benefits, purely and simply. Clearly, plaintiffs disagree with this Court's conclusion and it is their prerogative to do so.

In the present motion, however, plaintiffs do not point to precedents indicating a split of authority on this issue which might suggest a substantial ground for difference of opinion justifying interlocutory review in an extraordinary case. It does not suffice to claim that this is a matter of

first impression within this Circuit, unless there is considerable thrust to the argument that the relief sought by plaintiffs is not for plan benefits within the meaning of Section 502(a)(1)(B). To the contrary, the courts previously considering this issue have found that jurisdiction lies under Section 502(a)(1)(B), *see Franks v. Prudential Health Care Plan, Inc.*, 164 F.Supp.2d 865, 873 (W.D.Tex.2001); *Riemer v. Columbia Medical Plan, Inc.*, 1997 WL 33126252, at *1-2 (D.Md. Mar. 28, 1997); *Kaszula v. Parker*, 1997 WL 106267 (N.D. Ill. Feb. 13, 1997). As the Third Circuit has more recently stated, the test for Section 502(a)(1)(B) requires making a distinction:

> [T]he ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of medical treatment performed, which may be the subject of a state action.

Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 273 (3d Cir.2001). Quite simply, if plaintiffs are to succeed on their claims of unjust enrichment, they must prove they were entitled to receive and retain these plan benefits. Their entitlement to monetary benefits under their ERISA plans is an essential element of their unjust enrichment claims.

3. *Advance Termination of Litigation*

Plaintiffs finally argue that certification of this issue would materially advance the ultimate termination of the litigation because if the appellate court were to find a lack of jurisdiction, the case would be terminated in federal court and remanded to state court for consideration. Defendants correctly cited law from within the Third

Circuit which supported denying certification in circumstances such as these, where grant of certification would likely delay, rather than hasten, the ultimate termination of the case. *See Hulmes,* 936 F.Supp. at 211; *see also Singh v. Daimler-Benz AG,* 800 F.Supp. 260, 263 (E.D.Pa.1993) (refusing to certify remand issue), *aff'd,* 9 F.3d 303 (3d Cir.1993).

Plaintiffs have not shown that prolonged discovery or a lengthy trial will take place absent certification of this issue. To the contrary, the next issue to be addressed by this Court if it denies plaintiffs' request for certification is whether the case must be dismissed under Section 514 of ERISA. Plaintiffs argue that an interlocutory appeal could render future proceedings void and therefore would necessarily materially advance the termination of the litigation in this Court. This is far from clear; several defendants have already briefed dismissal motions under Section 514 of ERISA, and a briefing schedule was recently postponed[3] to consider this motion for interlocutory appeal. If defendants succeed in such dismissal, the cases would be ripe for appeal from a final order under 28 U.S.C. § 1291 within a short time. If the cases survive the dismissal motions, this calculus could be revisited. This Court finds, however, that plaintiffs have failed to meet their burden of showing that certification of the remand issue would materially advance termination of these proceedings.

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[3] A briefing schedule for defendants' dismissal motions in these consolidated cases is set forth in the accompanying Order, by which the consolidated dismissal motions should be fully briefed within 50 days.

3. *CONCLUSION*

For the reasons stated herein, this Court will deny plaintiffs' motion to alter or amend the May 28, 2002 Opinion and Order and also will deny the application for 28 U.S.C. § 1292(b) certification of the remand issue. Plaintiffs have failed to meet their burden of showing substantial ground for difference of opinion or that an interlocutory appeal would materially advance the ultimate termination of the litigation. Upon entry of a final order in this case, plaintiffs may appeal the case as a whole to the appellate court. This denial of Section 1292(b) certification is without prejudice. The accompanying Order is entered.

ORDER

This matter having come before the Court on plaintiffs' motion to alter or amend judgment and to stay further proceedings in the above-referenced action [Docket Item 33-1] pursuant to Rule 59(e), Fed.R.Civ.P. and for certification of an issue for interlocutory appeal pursuant to 28 U.S.C. § 1292; and this Court having reviewed the submissions by all parties; and for the reasons in the Opinion issued this date;

IT IS this ___ day of July 2002, hereby

ORDERED that plaintiffs' motion to alter or amend judgment and to stay further proceedings in the above-referenced action [Docket Item 33-1] be, and hereby is, *DENIED WITHOUT PREJUDICE;* and

IT IS FURTHER ORDERED that motions to dismiss shall be initiated pursuant to Appendix N within twenty (20) days of the date of this Order, and the complete brief

packets shall be due to this Court no later than thirty (30) days after the filing of the defendants' notices of intent; and

IT IS FURTHER ORDERED that parties refrain from repetitive briefing of identical issues and are encouraged to incorporate all or parts of similarly-situated parties' briefs by reference if appropriate.

204 F.Supp.2d 796

United States District Court,D. New Jersey.
Caroline CARDUCCI, et al., Plaintiffs,
v.
AETNA U.S. HEALTHCARE, Defendant.
Jean Levine, Plaintiff,
v.
United Healthcare Corp., Defendant.
Carole West, Plaintiff,
v.
Health Net of the Northeast, Defendant.
David Collins, Plaintiff,
v.
Oxford Health Plans, Defendant.
Noreen Bogurski, Plaintiff,
v.
Horizon Blue Cross Blue Shield of New Jersey, Defendant.
Benjamin Edmonson, Plaintiff,
v.
Horizon Blue Cross Blue Shield of New Jersey, Defendant.
Civil Action Nos. 01-4675(JBS), 01-4964(JBS), 01-5217(JCL), 01-5237(JWB), 01-5339(AMW), 01-5812(JBS).

May 28, 2002.

Natalie A. Finkelman, Esquire, Scott R. Shepherd, Esquire, James C. Shah, Esquire, Shepherd & Finkelman, LLC, and John W. Trimble, Jr., Esquire, Morrison & Trimble, Turnersville, NJ, for plaintiffs Carducci, Levine, and Edmonson.

Donna Siegel Moffa, Esquire, Franklin P. Solomon, Esquire, Weitz & Luxenberg, Cherry Hill, NJ, for plaintiffs West, Collins, and Bogurski.

Burt M. Rublin, Ramond A. Quaglia, Ballard Spahr Andrews & Ingersoll, LLP, for defendant Aetna U.S. Healthcare, Horizon Blue Cross Blue Shield of NJ, Horizon Healthcare Services.

Edward S. Wardell, Kelley, Wardell & Craig, LLP, Haddonfield, NJ, for defendant Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey and for Aetna U.S. Healthcare, Horizon Blue Cross Blue Shield of NJ, Horizon Healthcare Services.

William J. O'Shaughnessy, Esquire, Harvey C. Kaish, Esquire, B. John Pendleton, Esquire, McCarter & English, LLP, Newark, NJ, for defendants Oxford Health Plans, Inc. and Health Net of the Northeast, Inc.

Theodore D. Aden, Esquire, Carol A. Lafond, Esquire, Leboeuf, Lamb, Greene & McRae, LLP, Newark, NJ, and Edward A. Scallet, Esquire, Thomas F. Fitzgerald, Esquire, William F. Hanrahan, Esquire, Groom Law Group, Chartered, Washington, DC, for defendant United Healthcare Corp., k/n/a United Health Group, Inc.

Edward S. Wardell, Esquire, Raymond Quaglia, Esquire, Kelley, Wardell & Craig, LLP, Haddonfield, NJ, for defendant Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blue Shield of New Jersey.

OPINION

SIMANDLE, District Judge.

I. *INTRODUCTION*

This matter is presently before the Court on plaintiff's motion to remand this action to state court [Docket

Item 13-1], based on a lack of federal jurisdiction. Also pending before this Court is defendants' motion to dismiss plaintiffs' Complaints [Docket Item 13-1], which will be addressed, if necessary, in a later Opinion, if this Court determines that federal question jurisdiction exists over plaintiffs' complaints under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"). On January 28, 2002, this Court consolidated six cases[1] for the purpose of deciding the remand and, if necessary, the dismissal motions currently pending. Oral argument was heard on the remand issue on January 25, 2002 and April 4, 2002.

The specific issue presented by this remand motion is whether plaintiffs' state law unjust enrichment claims

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[1] Pursuant to this Court's January 28, 2002 Consolidation Order, which was consented to by the parties, the following cases were consolidated for the purpose of the instant remand and dismissal motions: *Carducci v. Aetna*, Civ. No. 01-4675(JBS) (lead case); *Levine v. United Healthcare Corp.*, Civ. No. 01-4964(JBS); *West v. Health Net of the Northeast*, Civ. No. 01-5217(JCL); *Collins v. Oxford Health Plans*, Civ. No. 01-5237(JWB); *Bogurski v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 01-5339(AMW); and *Edmonson v. Horizon Blue Cross Blue Shield of New Jersey*, Civ. No. 01-5812(JBS). As found in the consolidation order, the consolidated plaintiffs all filed lawsuits against their health insurance companies to recover monies collected by those companies pursuant to subrogation liens from subrogation clauses in their ERISA plans. Each of the consolidated claims posed similar legal and factual issues, namely, whether plaintiffs' claims for return of monies collected in subrogation by defendants after plaintiffs settled claims against third-party tortfeasors is within this Court's jurisdiction under Section 502(a)(1)(B) of ERISA. On April 5, 2002, the parties in another related action, *Bibbs v. Amerihealth, Inc.*, Civ. No. 02-1155(JBS), submitted a consent order that they would be bound by the Court's decision regarding remand in the above consolidated matters. At the initial oral argument on the remand motion, the parties in several other actions verbally indicated that they would be bound by the Court's decision in this case.

against their healthcare insurers, which allege that the subrogation clauses in their employee benefit health care contracts were made void and unenforceable by the New Jersey Supreme Court's decision in *Perreira v. Rediger,* 169 N.J. 399, 778 A.2d 429 (2001), are within federal court jurisdiction under Section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), and therefore properly removed by the defendants to federal court. Essentially, this Court must determine whether the monies plaintiffs now seek, that is the monies paid back to the defendants from plaintiffs' tort recoveries pursuant to the subrogation provisions in their ERISA plans, are "benefits due" under those plans, within the meaning of Section 502(a)(1)(B). Plaintiffs assert that the defendants have no valid right to subrogation from plaintiffs' tort recoveries under New Jersey law, and that the defendants' enforcement of the health care plans' subrogation provisions amounted to the unjust enrichment of the defendants contrary to New Jersey law.

For the reasons stated herein, the Court finds that plaintiffs' unjust enrichment claims are claims for "benefits due" under their ERISA plans, and therefore their state law claims are claims within Section 502(a)(1)(B) of ERISA and were properly removed to federal court. Plaintiffs' motion to remand this action and the consolidated cases to the Superior Court of New Jersey, Camden County, [Docket Item 13-1], and to the other originating Superior Courts of New Jersey, will therefore be denied.

II. *ANALYSIS*

It must be acknowledged that this case presents a conceptually unclear area of law. Plaintiffs' motion to

remand this action to state court requires this Court to determine whether there is federal removal jurisdiction over plaintiffs' claims of unjust enrichment, originally filed in the Superior Court of New Jersey, Camden County. To make that decision this Court must determine whether plaintiffs' claims fall within the purview of ERISA's civil enforcement provision, Section 502(a)(1)(B), and therefore whether plaintiffs' unjust enrichment claims are completely preempted by federal law.[2] The second, defendants' motion to dismiss, which will be addressed in a separate opinion only after federal jurisdiction is established, requires the Court to decide whether plaintiffs' state common law unjust enrichment claims must be dismissed as completely preempted under Section 502(a)(1)(B) or, alternatively, whether the claims are preempted as conflicting under Section 514(a).

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[2] The first round of remand briefing by plaintiffs focused primarily on Section 514 of ERISA, which addresses conflict preemption.

Complete preemption under Section 502, which is jurisdictional and relevant to the instant remand motion, is different from conflict or substantive preemption under Section 514, which displaces state law for federal law, but does not confer federal jurisdiction. *See Lazorko v. Pennsylvania Hosp.*, 237 F.3d 242, 248 (3d Cir.2000). The Third Circuit has repeatedly instructed that "'When the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption.'" *Pryzbowski*, 245 F.3d at 275 (quoting *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355 (3d Cir.)), *cert. denied*, 516 U.S. 1009, 116 S.Ct. 564, 133 L.Ed.2d 489 (1995). On January 28, 2002, this Court ordered supplemental briefing on the remand issue, focusing on the jurisdictional issues under Section 502. Any discussion of Section 514, if it is necessary, will be contained in a subsequent opinion addressing defendants' motion to dismiss.

Plaintiffs' Complaints allege only state law unjust enrichment claims, and plaintiffs assert that their cases must be remanded to state court for adjudication under New Jersey law, since no federal question jurisdiction exists under 28 U.S.C. § 1331, no federal diversity jurisdiction exists under 28 U.S.C. § 1332, and therefore no basis for removal under 28 U.S.C. § 1441 exists. Defendants argue that the cases were properly removed to federal court because plaintiffs are ERISA plan "participant[s] or beneficiar[ies]" who are seeking "to recover benefits due to [them] under the terms of [their] plan, [or] to enforce [their] rights under the terms of the plan" and therefore their unjust enrichment claims are completely preempted by the civil enforcement provision of ERISA.

A. *The "Well-Pleaded Complaint" Rule*

The Supreme Court in *Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 9-10, 103 S.Ct. 2841, 77 L.Ed.2d 420 (1983), held that "where there is no diversity of citizenship between the parties . . . the propriety of removal turns on whether the case falls within the original 'federal question' jurisdiction of the United States District Courts." *See Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 271 (3d Cir.2001). Defendants do not contest that there is no diversity of citizenship between the parties in these consolidated cases.

The "well-pleaded complaint" rule provides that federal question jurisdiction exists only when an issue of federal law appears on the face of the complaint. *See Pryzbowski*, 245 F.3d at 271. Anticipation of a federal defense by the defendant does not create federal jurisdiction. *See id.*

Complete preemption, an exception to the "well-pleaded complaint" rule, occurs when Congress so pervasively occupies a particular field (here, benefit enforcement claims under ERISA) that "any complaint that comes within the scope of [a] federal cause of action necessarily 'arises under' federal law," and is completely preempted. *Pryzbowski*, 245 F.3d at 271 (quoting *Franchise Tax Bd.*, 463 U.S. at 24, 103 S.Ct. 2841, 77 L.Ed.2d 420). The United States Supreme Court, in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987), held that Congress had intended that Section 502(a) of ERISA should have extraordinary preemptive force and that "causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court." *Metropolitan Life*, 481 U.S. at 66, 107 S.Ct. at 1542. Essentially, complete preemption functions to recharacterize plaintiffs' state law claims into federal claims for the purpose of removal, thereby creating federal removal jurisdiction.

B. *Complete Preemption of Claims Against HMOs Under Section 502(a)(1)(B) of ERISA*

Section 502(a)(1)(B) provides, in relevant part:

> **(a) Persons Empowered to Bring Civil Action.** – A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

Section 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B). There is no dispute that plaintiffs are all participants or beneficiaries of an ERISA plan. All parties also acknowledge that the third provision in Section 502(a)(1)(B), "to clarify ... rights to future benefits under the terms of the plan," does not apply here.

The Third Circuit most recently addressed the issue of ERISA preemption under Section 502(a)(1)(B) in *Pryzbowski*, and articulated the test to be applied when determining whether complete preemption exists:

> [T]he ultimate distinction to make for purposes of complete preemption is whether the claim challenges the administration of or eligibility for benefits, which falls within the scope of § 502(a) and is completely preempted, or the quality of medical treatment performed, which may be the subject of a state action.

245 F.3d at 273. This test clarified the distinctions made by the Third Circuit in previous cases in this area, which used a quality/quantity of care analysis. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.1995) (quality of benefits claims do not fall within Section 502(a)(1)(B), whereas claims challenging the quantum of benefits due under an ERISA-regulated plan are completely preempted under ERISA's civil enforcement scheme); *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir.1999) (classifying HMO's adoption of a policy of discharging newborn infants within 24 hours after delivery was a medical determination not preempted under Section 502(a)(1)(B)); *Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3d Cir.2000) (holding that the denial of a beneficiary's request for hospitalization for mental illness occurred in the course of treatment, and was therefore not preempted).

As acknowledged by the Third Circuit in *Pryzbowski*, the quality/quantity distinction is not always clear. Plaintiffs here do not argue that defendants made their decision to assert and recover subrogation and reimbursement liens in the course of treatment, nor do they assert that this was an administrative decision. Rather, they argue, similar to Pryzbowski, that the claims they assert against defendants do not fit within Section 502(a)(1)(B), ERISA's civil enforcement provision, because they are not benefits under the plan. *See Pryzbowski*, 245 F.3d at 272; 29 U.S.C. § 1132(a). Plaintiffs assert that the monies they are seeking, which defendants recovered pursuant to the subrogation provision contained in their ERISA plan contracts, are not benefits under the plan. Plaintiffs also argue that this action is for unjust enrichment, not to enforce any rights they have under the terms of their ERISA plans, nor to recover benefits due under their ERISA plans. Defendants assert that the monies sought to be recovered here are a part of the benefits bundle originally provided for plaintiffs' medical care pursuant to the plans, and therefore plaintiffs' claims are seeking benefits under the plan.

The instant case does not fall neatly into the distinction of administration of benefits or medical treatment benefits, nor is the quantity/quality of care distinction helpful to this analysis. Plaintiffs claims are, however, in light of the Third Circuit case law in this area, more like an administrative complaint than a medical complaint, because they relate to the amount of benefits to which they are due under the ERISA plan. There is no dispute here about the fact of medical services having been rendered under the plan. It is an external event, namely, the plaintiffs' recoveries of tort judgments or settlements

embracing compensation to plaintiffs for the same medical treatment which triggers the administrative operation of the subrogation mechanism. Although it was not an administrative decision prior to the rendering of health care, as was the case in previous Third Circuit decisions, the plans' recovery in subrogation here was previously made pursuant to the terms of the plan and directly concerns the ultimate amount of benefit to which plaintiffs are entitled under the respective health care plans.

C. *Whether Plaintiffs Seek Benefits Due Under the Plan*

Plaintiffs worded their Complaints to assert only state law claims. The complete preemption exception to the well-pleaded complaint rule, however, requires this Court to determine whether the monies plaintiffs seek are actually "benefits due . . . under the terms of [the] plan" or "rights under the term of the plan." Section 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B). In order to do that, this Court must determine whether the monies sought by plaintiffs to be recouped from the defendants are benefits under the term of the plan or some other thing. Plaintiffs argue that the monies they seek, which were paid to defendants pursuant to a subrogation lien and the subrogation paragraph in the ERISA plans, are separate from the benefits they received as a result of the plan. Plaintiffs aver that their benefits under the plan were concluded when they received treatment and their medical bills were paid. Defendants argue that the monies plaintiffs seek constitute benefits under the plan because they represent a portion of the sum (benefits) initially expended by defendants for plaintiffs' medical care, which is necessarily based upon the terms of their respective plans. Defendants

assert that plaintiffs' unjust enrichment claims are just another way of seeking additional benefits they feel they are due under their plan.

Plaintiffs' complaints[3] describe the nature of their claims as follows:

> This is an action seeking to undo defendant's unjust enrichment. Plaintiffs and class members previously were plaintiffs in personal injury lawsuits in New Jersey, and in connection with the settlement of their lawsuits caused to be paid out of settlement proceeds subrogation or reimbursement to [defendants] to satisfy [defendants'] subrogation or reimbursement liens. Although these liens had been filed pursuant to contract language purportedly permitting them, the New Jersey Supreme Court [in *Perreira v. Rediger, supra*] recently held that New Jersey law does not, and never did, allow insurers like defendant to file or assert reimbursement or subrogation liens.(Removal Notice, Ex. A, Compl. at 1-2.) In their claim for unjust enrichment, plaintiffs assert that defendants have been unjustly enriched and unlawfully asserted subrogation and reimbursement liens. (Compl., ¶¶ 41-42.) Plaintiffs acknowledge that the liens asserted by defendants were originally provided for in their ERISA plans. Plaintiffs request relief in the form of return of the monies received by defendants pursuant to these liens, which they now claim

[3] Plaintiffs acknowledged that the facts underlying each of the consolidated cases are similar, and that it would be fair to assume that each of them asserted a Carducci-like claim. (Apr. 4, 2002 Tr. 38:2-20.) For the sake of brevity, this Court will refer only to the language of Ms. Carducci's claim.

> are contrary to New Jersey law. (Compl., at 8, ¶¶ B-C.)

The classification of the monies sought by plaintiff was addressed at length in oral argument before this Court.

Plaintiffs concede that the monies plaintiffs now seek had their genesis as benefits. (Apr. 4, 2002 Tr. 11:4-9.)

Plaintiffs argue, however, that the benefits under the plan were completed once the healthcare was received by plaintiffs and paid for by defendants. (*Id.* Tr. 11:11-22.) When asked by the Court, plaintiffs' counsel was unable to give a clear statement of what the monies they sought were if not benefits:

> THE COURT: And so when the plan comes along and asserts a purported contractual right to subrogation and receives that same $180 then as proceeds from Carducci's settlement, what's the nature of that bundle of money, that $180?
>
> MR. SOLOMON: I'm not sure what you mean by the nature of that, Judge.
>
> THE COURT: Well, what is it? Is it a contract recovery that the plan has made? Is it money that rightly always belonged to the plan and no one else? Where does this $180 come from? What is it that gives the plan the right to take it out of the plaintiff's settlement?
>
> MR. SOLOMON: Well, purportedly it's the contract reimbursement provision under the plan that gives them the right to assert that claim.

(Apr. 4, 2002 Tr. 11:23-12:12.) The Court again questioned about the nature of the money sought, and plaintiffs' counsel responded:

> THE COURT: You've argued that the $180 shouldn't be characterized as benefits, it's not benefits under the plan. Benefits has a different meaning, and that meaning is healthcare services that were rendered and paid for by the plan. And so if it's not benefits, then what is it?
>
> MR. SOLOMON: Well, I think what we would argue is that this was money that was wrongfully taken from the plaintiffs under state law. This is a, you know, a windfall to the plan that was taken in contravention of state law, of the collateral source statute, and the unjust enrichment law. . . . To the extent that there's any contractual provision that purportedly gives them a right, that contractual provision was never valid, it should never have been permitted to be incorporated into the plan.

(*Id.* at Tr. 13:16-14:8.)

Plaintiffs, in their supplemental reply brief in support of remand, cite to the Supreme Court's decision in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204, 122 S.Ct. 708, 151 L.Ed.2d 635 (2002), for the proposition that there is no contractual right under ERISA's civil enforcement provision to demand subrogation or reimbursements from their insureds. (*See* Pl.'s Supp. Reply Br. at 3-4.) Plaintiffs assert that the Supreme Court in *Great-West* held that Section 502(a)(3) supplies no cause of action for a health plan's claimed contractual right of reimbursement. (*Id.* at 4.) Defendants responded to the citation of *Great-West*, arguing that *Great-West* is

distinguishable because it involves a separate ERISA provision (Section 502(a)(3) instead of Section 502(a)(1)(B)) and also because the decision is much narrower than plaintiffs represent.

Contrary to plaintiffs' argument, the Supreme Court merely held that where the *fiduciary* seeks contractual reimbursement, it cannot overcome the limitation under § 502(a)(3) which by its terms allows the fiduciary to seek only "equitable" relief. *Great-West*, 122 S.Ct. at 712-13. The Court contrasted the limitation of § 502(a)(3) to the more expansive language of § 502(a)(1)(B), which permits "'a participant or beneficiary' to bring a civil action 'to enforce his rights under the terms of the plan,' without reference to whether the relief sought is legal or equitable. . . ." *Great-West*, 122 S.Ct. at 718-19 (quoting § 502(a)(1)(B)). Thus, nothing in *Great-West* suggests that a participant or beneficiary does not have the ERISA right to seek reimbursement of benefits under the plan under § 502(a)(1). Since either legal or equitable relief is available to a participant or beneficiary under § 502(a)(1), the *Great-West* holding is limited to matters arising under § 502(a)(3).[6]

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[6] In *Great-West*, the fiduciary for an employee health plan sought to recover reimbursement from a plan beneficiary for the medical expenses which it had paid for. The fiduciary alleged that the plan's reimbursement provision permits it to recover from a beneficiary the prior payments it has made, where the beneficiary is entitled to recover from a third party. Great-West invoked § 502(a)(3)(B) of ERISA, 29 U.S.C. § 1132(a)(3), which authorizes a participant, beneficiary or fiduciary to file a civil action "(A) to enjoin any act or practice which violates . . . the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of . . . the terms of the plan." The Supreme Court examined the nature of relief sought by the fiduciary – to impose a contractual obligation upon the beneficiary to pay money – and found that this did

(Continued on following page)

Plaintiffs also cite to two Seventh Circuit decisions in support of their position that the monies they seek are not benefits. First, plaintiffs cite *Speciale v. Seybold*, 147 F.3d 612 (7th Cir.1998), for the proposition that an action to adjudicate a lien, or a declaratory judgment action to order the distribution of settlement proceeds among ERISA plans and other creditors does not create a federal cause of action under ERISA. Plaintiffs argue that their claims were the same sort as those asserted in *Speciale*, although slightly later in the process. Next, plaintiffs cite *Blackburn v. Sundstrand Corp.*, 115 F.3d 493 (7th Cir.1997), which involved two beneficiaries of an ERISA plan who were injured in an automobile accident. The *Blackburn* court held that removal under ERISA preemption was improper based upon the well-pleaded complaint rule and the determination that "not even the most expansive reading of ERISA covers motor vehicle collisions, just because a part of the recovery may inure to the benefit of a plan." 115 F.3d at 494; *see Speciale*, 147 F.3d at 616.

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not constitute "equitable relief" as required by § 502(a)(3)(B), *supra*. The Supreme Court repeated its observation that ERISA's "carefully crafted and detailed enforcement scheme provides 'strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Great-West*, 122 S.Ct. at 712 (quoting *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 254, 113 S.Ct. 2063, 124 L.Ed.2d 161 (1993)) (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985)). The *Great-West* majority thus gave a historical reading to the statutory term "equitable relief" and found that the fiduciary failed to demonstrate that its desired remedy was within § 502(a)(3). The holding is of tangential application to the present matter, but it does serve to remind us of the importance of precision in the textual interpretation of ERISA, since "vague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the *specific* issue under consideration." *Great-West*, 122 S.Ct. at 718 (quoting *Mertens*, *supra*, 508 U.S. at 261, 113 S.Ct. 2063).

Both Seventh Circuit cases, which are not controlling here, are distinguishable. First, the court in *Speciale* held that there is no preemption "in a state cause of action where there are adversarial claims to a settlement fund between an ERISA plan subrogation claim and other statutory medical liens" because the allocation of settlement funds is a matter for the state court. *Speciale*, 147 F.3d at 617. So, unlike plaintiffs here, who seek to recoup funds previously paid in subrogation and who vigorously contest defendants' subrogation rights as provided for in their ERISA plans, Speciale merely wanted her liens adjudicated and her settlement disbursed. *Id.* at 614. The Seventh Circuit determined that where plaintiff seeks a recovery for a breach of state law duty, and no contract interpretation is required, as was the case with Speciale, there is no preemption. *Id.* at 615. However, the court went on to write that "where state law has the effect of creating a qualitative standard (e.g., 'bad faith' or 'improper') by which the performance of a contract is evaluated, then that state law is completely preempted." *Id.* Plaintiffs' unjust enrichment claim in the present case, that defendants unlawfully asserted subrogation liens against them, even under the non-binding Seventh Circuit precedent, would also be preempted since plaintiffs rely on state law to strike a portion of their ERISA plan contract. *Blackburn* too involved a state court action to apportion the funds between their attorney and their ERISA welfare benefit plan, not a challenge of the fund's subrogation rights. *See* 115 F.3d at 494.

Defendants argue, and this Court agrees, that plaintiffs' present claims are actually claims for benefits under the ERISA plans. Essentially plaintiffs seek to regain the whole benefit provided to them by defendants, including

those amounts paid in subrogation pursuant to the terms of the plans. Although plaintiffs argue that no interpretation of the ERISA plan is required, that is not so. In order to award plaintiffs the relief they seek, this Court must determine the content of the ERISA plan and whether the New Jersey Supreme Court case in *Perreira* applies to the subrogation provision in plaintiffs' ERISA plans. Plaintiffs' argument that it is clear that the subrogation provisions are voided by *Perreira* may very well be correct, but for the purpose of determining federal jurisdiction, this Court need only determine that the complaints seek benefits due under the terms of the plan. Because this Court finds that plaintiffs' claims seek to recoup a benefit due under the plan (that is the entire benefit amount paid as opposed to the benefit minus the subrogation loan), the Court holds that plaintiffs' claims are completely preempted under Section 502(a)(1)(B), and that removal was proper. Plaintiffs' motion to remand will be denied.

III. *Conclusion*

For the reasons stated herein, and this Court having found that plaintiffs' claims are within federal court jurisdiction under Section 502(a)(1)(B) of ERISA, plaintiffs' motion to remand [Docket Item 13-1] will be denied. The accompanying Order is entered.

ORDER

This matter having come before the Court on plaintiffs' motion to remand this action to state court [Docket Item 13-1]; and this Court having reviewed the submissions and supplemental submissions on the remand issue by all parties; and this Court having heard oral argument

on the remand issue on January 25, 2002 and April 4, 2002; and for the reasons in the Opinion issued this date;

IT IS this ___ day of May, 2002, hereby

ORDERED that plaintiffs' motion to remand this action to state court [Docket Item 13-1] be, and hereby is, ***DENIED***; and

IT IS FURTHER ORDERED that the parties shall convene for oral argument on the remaining motion in this action, defendants' motion to dismiss pursuant to Rule 12(b)(6), Fed.R.Civ.P. [Docket Item 10-1], on **Monday, June 10, 2002 at 11:00 a.m.** before the undersigned in **Courtroom 4A**.

THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 04-1224
No. 04-1225

JEAN LEVINE, On behalf of
herself and all other similarly situated

v.

UNITED HEALTHCARE CORPORATION

(DC NJ 01-cv-04964)

NOREEN BOGURSKI

v.

HORIZON BLUE CROSS
BLUE SHIELD OF NEW JERSEY

(DC NJ 01-cv-05339)

BENJAMIN EDMONDSON, On behalf of
Himself and All Other Similarly Situated

v.

**HORIZON HEALTHCARE SERVICES, INC.,
dba
Horizon Blue Cross Blue Shield of New Jersey

(DC NJ 01-cv-05812)

United Healthcare Corporation
Horizon Blue Cross Blue Shield of New Jersey,

Appellants

**(Pursuant to Court's Order of 3/24/05)

On Appeal from the United States District Court
for the District of New Jersey

SUR PETITION FOR REHEARING

BEFORE: SCIRICA, *Chief Judge*,
NYGAARD, ALITO, ROTH, MCKEE,
BARRY AMBRO, SMITH, FUENTES,
FISHER, and VAN ANTWERPEN
and GARTH, *Circuit Judges*,[1]
and POLLAK, *District Judge*[2]

The Petition for rehearing filed by the Appellees/ Cross-Appellants in the above-entitled matter having been submitted to the judges who participated in the decision of this court and to all other available circuit judges in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges in regular active service not having voted for rehearing by this court en banc, the Petition for Rehearing is hereby DENIED.

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[1] Judge Garth's vote is limited to panel rehearing only.

[2] The Honorable Louis J. Pollak, Senior District Judge for the United States District Court for the Eastern District of Pennsylvania, sitting by designation. Judge Pollak's vote is limited to panel rehearing only.

It is so ordered.

By the Court,

/s/ Richard L. Nygaard
United States Circuit
Judge

DATE: June 24, 2005

par/cc: F.P.S., Esq.
D.S.M., Esq.
N.F.B., Esq.
E.S.W., Esq.
E.A.S., Esq.
W.F.H., Esq.
J.H.E., Esq.

MOTION FILED

OCT 27 2005

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Supreme Court, U.S.
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OCT 27 2005
OFFICE OF THE CLERK

No. 05-387

IN THE

Supreme Court of the United States

JEAN LEVINE AND NOREEN BOGURSKI, PETITIONER

v.

UNITED HEALTH CARE CORP. AND HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF AMICUS CURIAE AMERICAN TRIAL LAWYERS ASSOCIATION – NEW JERSEY IN SUPPORT OF THE PETITIONER

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INTEREST OF *AMICUS CURIAE*

The interest of ATLA-NJ in this matter is set forth in the accompanying motion for leave to file this brief as *amicus curiae* in support of Petitioner.[1]

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE*

The Association of Trial Lawyers of America-NJ ("ATLA-NJ") hereby moves, pursuant to Rule 21 of the Rules of this Court, for leave to file the attached brief as *amicus curiae*, suggesting that the decision below should be reversed.[2] ATLA-NJ additionally moves for leave to argue the cause orally on the side of Petitioner pursuant to Supreme Court Rule 28. Petitioner has consented to the within request.

ATLA-NJ dedicates itself to ensuring that New Jerseyans have access to a clean environment, safe merchandise, suitable health-care, and safe workplaces. ATLA-NJ, which was founded nearly sixty years ago, is a state-wide organization comprised of some 2,300 lawyers and law-trained individuals. ATLA-NJ is affiliated with several entities which together provide

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[1] The within brief was prepared exclusively by counsel for *amicus curiae* ATLA-NJ. No contributions to the preparation of the within brief were made by either Petitioner or Respondent. With the exception of *amicus curiae* ATLA-NJ, its members and its counsel, no monetary contribution with respect to preparation and submission of the within brief was provided.

[2] Pursuant to Rule 37(b) of the Rules of this Court, ATLA-NJ has requested, but has not received, the Respondent's consent to the filing of the attached brief as *amicus curiae*. Petitioner has consented thereto.

information to New Jerseyans regarding their rights at law, legislative and political input, and continuing legal education to attorneys.

ATLA-NJ counts among its objectives the preservation of the jury system and support for rights of those injured in tort.[3] Many of the individuals whom ATLA-NJ endeavors to protect are participants in group health insurance arrangements subject to Title I of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et. seq.* ("ERISA"). Frequently, victims of tort receive health insurance benefits as a result of these injuries. Upon notification that the injured party is seeking legal redress, ERISA health insurance plans often assert a lien against the recovery from the tort action. ATLA-NJ is devoted to ensuring that tort victims against whom ERISA liens are asserted have the ability to identify, investigate, and verify the legitimacy of asserted liens. ATLA-NJ also maintains an interest in ensuring that the subordinate federal courts adhere to the savings clause analysis set

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[3] ATLA–NJ has identified its mission as:

> to uphold and defend the Constitution of the United States and of the State of New Jersey; to advance the science of jurisprudence; to educate and train in all fields and phases of advocacy; to promote the administration of justice for the public good; to uphold the honor and dignity of the profession of the law; and especially to advance the cause of those who are damaged in person or property and who must seek redress therefore; to encourage brotherhood among the members of the bar; and to uphold and improve the adversary system and trial by jury.

Mission Statement, ATLA-NJ (*available on the Internet: www.atlanj.org; site last visited October 26, 2005*).

out in *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003).

ATLA-NJ believes that its participation in briefing and argument of this case will enable it to render greater assistance to, and materially aid, this Honorable Court in rendering a just decision on the merits of this appeal.

Wherefore, ATLA-NJ prays that this Court grant its motion to file its brief *amicus curiae* and to argue orally on the side of Petitioners herein.

SUMMARY OF ARGUMENT

The Petition for Writ of Certiorari involves the interpretation of ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). It is well-settled that ERISA's genesis was spurred forth by concerns for the safety of employee benefit plans and the rights of workers to receive benefits therefrom. 29 U.S.C. § 1001(a)("*Congressional findings and declaration of policy*"). The legislative intent of ERISA's preemption provision focuses on uniformity of regulatory standards. Rather than subject ERISA plans to a myriad of varying state regulation, Congress intended to increase administrative efficiency and reduce costly amendments tailored to each state's individual requirements. Early ERISA preemption jurisprudence involving the savings clause drew upon the McCarran-Ferguson Act's directive that the business of insurance is solidly within the purview of state authority. This Court's more recent preemption decisions have not varied significantly from concerns of uniformity. And although this Court's holding in *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003), replaced the McCarran-Ferguson test with a newer, two-part

test for aligning savings clause disputes, the business of insurance is still undisputedly within the ambit of state sovereignty.

In the instant Writ of Certiorari, the United States Court of Appeals for the Third Circuit held that New Jersey's statutory prohibition against certain litigation/insurance offsets is not a state law regulating insurance and, therefore, is not saved from ERISA preemption. *Levine v. United Heathcare*, 402 F.3d 156 (2005). The Third Circuit's decision undermines the legislative intent to promote uniformity behind the preemption provision. The Third Circuit's decision also improperly invades New Jersey's sovereign authority to determine how it chooses to regulate the business of insurance. Put bluntly, the decision below runs afoul of the "common sense" inquiry invited by earlier savings clause jurisprudence. That is to say, as noted by the dissent below, the Third Circuit's decision accords too little weight to statements by New Jersey's highest court and the New Jersey legislature that New Jersey's statutory prohibition is indeed a law directed at the insurance industry. *Id.* at 169 (Garth, J., dissenting).

Finally, the Third Circuit's decision is inconsistent with the seminal legislative concerns which drove the ERISA legislative into law: workers' access to plan benefits. 29 U.S.C. § 1001(a)(*discussing the national need to protect "anticipated" employee benefits*). By allowing insurance companies to attach and diminish workers' employee benefits, a federal court has permitted insurance companies to do what New Jersey has indicated insurers may not do. The unfairness of the result below is presented in stark terms where individual consumers of health insurance products would have greater protections than those

individuals who receive health insurance from ERISA benefit plans.

As set forth herein, ERISA's legislative history is clear that our Nation's federalist system of government was not to be displaced. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981). New Jersey has the right to craft and interpret its own insurance law. Recognition of this right also contributes to the policy objectives of ERISA. Subordinate courts sitting in ERISA matters should be advised not to stray from now-settled savings clause standards.

LEGAL ARGUMENT

POINT I

KENTUCKY ASS'N'S TWO-PART SAVINGS CLAUSE TEST PRESERVES AS GUIDANCE VALUE THE McCARRAN-FERGUSON FACTORS

The *Employee Retirement Income Security Act of 1974*, 29 U.S.C. § 1001, *et. seq.* ("ERISA"), was passed for the generalized purpose of protecting workers' access to employee benefits. ERISA's preemption component, however, was not the product of appreciable legislative discussion. *See* 33 *Harv. J. on Legis.* 35, 52-56 (1996)(*discussing the paucity of legislative history on ERISA preemption).* As such, current preemption doctrine commences with the following directive: "We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *New York*

State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 656 (1995)("*Travelers*").

In the within matter, the United States Court of Appeals for the Third Circuit held that the savings clause to ERISA's preemption provision did not "save" from ERISA preemption New Jersey's statutory prohibition against deductions from plaintiffs' personal injury awards, N.J.S.A. 2A:15-97 (the "New Jersey Rule"). *Levine v. United Healthcare*, 402 F.3d 156 (3d.Cir, 2005). The *Levine* Court opined that the New Jersey Rule was not "directed at" the business of insurance. In so doing, the Court held that the two-factor savings clause test set out in *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003)("*Kentucky Ass'n*"), had not been satisfied and full preemption by the federal ERISA law was thus warranted.

In *Kentucky Ass'n*, this Court voided the old McCarran-Ferguson test for identifying the "business of insurance" in favor of a stylized, two-part test:

> Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a 'law . . . which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements. **First**, the state law must be specifically directed toward entities engaged in insurance . . . **Second**, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

Id. at 341-42 (*ellipses original; internal cites removed; bold-face type supplied*).

The new paradigm set out in *Kentucky Ass'n*, however, was superimposed against various prohibitions and directives as set out in the opinion. First, the Court held that the savings clause is not concerned if a particular practice amounts to "the business of insurance. . . ." *Id.* at 340. Second, the *Kentucky Ass'n* Bench observed that the savings clause is not concerned if a state's law was passed "for the purpose of regulating the business of insurance. . . ." *Id.* (*internal emphasis removed*). Third, the Supreme Court noted that to be saved from federal preemption, a state's insurance law need not affect only insurers. *Id.* at 335-36. The Third Circuit's decision in *Levine* followed two years later.

POINT II

THE DECISION BELOW DETRACTS RATHER THAN CONTRIBUTES TO THE UNIFORM REGULATION OF PLANS AS WAS INTENDED BY THE ERISA PREEMPTION PROVISION

ERISA's preemption provision has a two-fold purpose: first, to subject plans to a uniform set of regulatory requirements; and second, to encourage (with such uniformity) ease in administration of and efficiency in operation of employee benefit plans. *See Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987). Against which, "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.'" *Id.* at 19 (*quoting Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)).

Similarly, this Court has recognized the need for a workable, coherent paradigm upon which to align